98th Congress, 1st Session - - - - - - - - House Document No. 98-24

HEALTH INCENTIVES REFORM PROGRAM

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

LEGISLATIVE PROPOSALS TO RESTRUCTURE THE MEDICARE HOSPITAL INSURANCE PROGRAM; TO AMEND THE INTERNAL REVENUE CODE OF 1954 TO PROVIDE FOR THE INCLUSION OF CERTAIN EMPLOYER CONTRIBUTIONS TO HEALTH PLANS IN AN EMPLOYEE'S GROSS INCOME; TO PROVIDE FOR VOLUNTARY PRIVATE ALTERNATIVE COVERAGE FOR MEDICARE BENEFICIARIES, AND FOR OTHER PURPOSES; TO MAKE IMPROVEMENTS IN THE MEDICARE AND MEDICAID PROGRAMS, AND FOR OTHER PURPOSES; AND TO PROVIDE FOR PROSPECTIVE PAYMENT RATES UNDER MEDICARE FOR INPATIENT HOSPITAL SERVICES, AND FOR OTHER PURPOSES

FEBRUARY 28, 1983.—Message and accompanying papers referred to the Committees on Ways and Means and Energy and Commerce and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

17-039 O WASHINGTON: 1983

To the Congress of the United States:

I am today transmitting to the Congress legislation comprising the Health Incentives Reform program. This legislation reforms health care financing policies to constrain rising health care costs and to keep high quality health care affordable for all Americans. Because of the coming shortage in the Medicare Trust Fund, prompt action is particularly important.

This legislative package addresses the underlying causes of excessive increases in health costs: the perverse incentives operating in the market for health services. Cost-based reimbursement, poorly structured cost-sharing, and open-ended tax subsidies for health insurance have contributed to inefficiency and inflation in the health sector. Our proposals correct these incentives. Our plan involves all participants in the health care market in restructuring financing and service delivery arrangements: providers and patients, physicians and hospitals, and beneficiaries of public programs as well as privately insured workers. Thus it shares the responsibility for bringing down health care costs fairly among all segments of society.

THE HEALTH CARE COST PROBLEM

The need for action now is clear. Health care costs are climbing so fast they may soon threaten the quality of care and access to care which Americans enjoy. In 1982 health care costs went up almost three times the national inflation rate. Taxpayers have seen Federal outlays for Medicare and Medicaid go up nearly 600 percent since 1970. Health care funding is one of the fastest-rising expenditures in the Federal budget. The cost of health insurance rose 15.9 percent in 1982, the biggest increase ever. Health care costs are consuming a growing portion of the Nation's output: 10.5 percent of GNP in 1982, compared with 5.9 percent in 1965.

The cost of the average hospital stay jumped from $316 in 1965 to $2,168 in 1981. American taxpayers (mainly through Medicare and Medicaid) pay a large part of those costs: 40 percent of all hospital bills.

Rising health care costs are a problem that affects everyone. The elderly, who are covered by Medicare, face the threat of catastrophic illness expense, against which Medicare offers no protection. The poor on Medicaid have seen coverage reduced as States have been forced by rising costs to make cutbacks. Workers with employment-based health insurance have received lower cash wages, because of the unchecked cost increases for health benefits. Americans pay for health care costs in other hidden forms, including higher costs for the merchandise they buy, since the costs of employee health care benefits must be included in the price of products.

As is the case with many of our national difficulties, past Federal policy has been a part of the problem. These policies have thwarted normal incentives for efficiency in health care.

- Medicare's cost-based system has actually rewarded inefficiency by paying more to less efficient, higher cost hospitals.
- Cost sharing in Medicare has been backwards. Those who are less ill, and could act to keep their hospital stays shorter have been given no cost incentive to do so, and severely ill patients have been penalized with high cost sharing and no catastrophic coverage.
- Federal tax policy has created a bias for high priced medical coverage instead of wages, since employer contributions to health care benefits are not treated as income to the employee.
- Federal health care programs have made too little use of competitive bidding practices.
- Medicare beneficiaries have been unable to enroll in efficient private health plans.
- Unnecessary regulations have added to higher costs in past years.

THE ELEMENTS OF HEALTH INCENTIVES REFORM

The Health Incentives Reform package contains a number of specific provisions which address each facet of our multi-pronged strategy. First, it initiates Medicare coverage for the catastrophic costs of lengthy hospital stays and improves Medicare's cost-sharing provisions. These reforms encourage efficiency while reducing the cost burden on the severely ill.

The plan establishes a prospectively-set hospital rate structure under Medicare that rewards cost-effective hospital practices. This contrasts with the traditional Medicare policy of reimbursing hospitals retrospectively for whatever "reasonable" costs they incurred.

The plan limits the open-ended tax subsidy of relatively high-cost private health plans, which biases employee compensation towards elaborate health coverage instead of cash wages.

The plan expands opportunities for Medicare beneficiaries to use their benefits to enroll in private health plans as an alternative to traditional Medicare coverage.

The plan freezes payments to physicians under Medicare's reasonable charge system for one year at 1983 levels.

The plan provides for gradual yearly increases in the Medicare Part B premium and deductible once again to cover a sufficient portion of the program's costs through beneficiary payments.

The plan expands authority under Medicare for the use of competitive bidding procedures and other cost efficient approaches for the purchase of laboratory services, durable medical equipment, and other non-physician services and supplies. Furthermore, payment for durable medical equipment provided through home health agencies would be limited to 80 percent, the same percentage covered by Medicare under other circumstances.

A provision of the plan will entitle the elderly to Medicare benefits on the first day of the full month that individuals meet all eligibility conditions. At present, entitlement begins on the first day of the month in which an individual meets the conditions for only one day. This proposal is consistent with initial Social Security eligibilities for individuals who attain age 62. Also, most private insurance coverage

now remains in effect until Medicare coverage begins; thus most beneficiaries would not be affected.

Finally, the plan makes two changes in Medicaid. The reduction in Federal payments to States authorized by the Omnibus Budget Reconciliation Act of 1981 would be extended beyond 1984 for an indefinite period. The reduction would be cut, however, from 4.5 percent to 3 percent. In addition, Medicaid beneficiaries would have to make nominal copayments for outpatient visits and hospital stays.

Our legislative package contains additional Medicare and Medicaid provisions to strengthen program management, simplify requirements for program participation, produce savings in program spending, and reduce waste, fraud and abuse in these programs.

MEDICARE CATASTROPHIC COVERAGE AND COST-SHARING REFORM

The "Medicare Catastrophic Hospital Costs Protection Act of 1983" improves coverage for long and expensive hospitalizations and introduces modest coinsurance on the initial days of hospitalization.

The current Medicare Hospital Insurance program neither adequately protects beneficiaries in cases of prolonged illness, nor provides financial incentives to minimize unnecessary utilization of services. Medicare covers only 90 to 150 days of hospitalization during a spell of illness (depending on whether a "lifetime reserve" of 60 days has been previously exhausted), even if additional hospitalization is clearly warranted. After the 60th day, cost sharing becomes onerous. Patients pay 25 percent of the inpatient hospital deductible ($88/day) for the 61st to 90th day and 50 percent ($175/day) for lifetime reserve days. On the other hand, after a deductible is paid for the first day, no coinsurance at all is imposed until the 61st day of hospitalization, eliminating any financial incentive for the beneficiary to leave a hospital as soon as it is medically advisable to do so.

The bill provides Medicare reimbursement for unlimited days of hospitalization under the Medicare Hospital Insurance program. At the same time, the bill imposes coinsurance for a maximum of 60 days annually (8 percent of the inpatient hospital deductible for the 2nd through 15th day of a spell of illness and 5 percent thereafter) to encourage beneficiary cost-consciousness and the efficient use of health resources. The bill also limits to two the number of inpatient hospital deductibles that could be imposed annually (no matter how many spells of illness occur) and reduces the skilled nursing facility coinsurance rate from 12.5 to 5 percent of the inpatient hospital deductible.

PROSPECTIVE PAYMENT FOR INPATIENT HOSPITAL SERVICES UNDER MEDICARE

The "Medicare Prospective Payment Rates Act" will establish Medicare as a prudent buyer of services and will ensure for both hospitals and the Federal government a predictable payment for services. This system of payment can be implemented in October, 1983.

Medicare traditionally paid hospitals retrospectively determined reasonable costs. This system essentially paid hospitals for whatever they spent. There were, therefore, weak incentives for hospitals to conserve costs and operate efficiently. It is not surprising that under this system hospital expenditures have been and are continuing to

increase rapidly. Medicare expenditures for hospital care have increased 19 percent annually from 1979 to 1982. The cost of a service varies substantially from hospital to hospital.

The Tax Equity and Fiscal Responsibility Act (TEFRA) changed this system of hospital reimbursement by placing limits on what hospitals could be paid. My proposal builds upon the TEFRA improvements. This bill establishes a system of prospectively determined rates which will foster greater efficiency in the provision of hospital services. Medicare payments for operating costs will be specifically related to the patient's condition, but will not vary from hospital to hospital (except to allow for differences in area wage rates). Rates will be set for each of 467 diagnosis-related groups. Capital expenditures and medical education costs will be excluded initially from the calculation of basic payments and reimbursed separately. Additional payments will be made for unusual cases involving exceptionally long hospital stays.

To the extent that a hospital operates efficiently it would earn a surplus, and to the extent it operates inefficiently it would show a deficit. Hospitals with higher costs will not be able to pass on extra costs to Medicare beneficiaries and thus will face strong incentives to make cost-effective changes in practices.

CHANGES IN THE TAX TREATMENT OF EMPLOYER CONTRIBUTIONS TO HEALTH PLANS

The Health Costs Containment Tax Act of 1983 is designed to encourage employers to provide an adequate level of health benefits to their employees, while eliminating the open-ended tax preference for health benefits over cash wages.

Under current tax law an employer's contribution to an employee's health plan is not included in the employee's gross income. This bill will limit tax-free health benefits paid by an employer to $175 per month for a family plan and $70 per month for individual coverage. These limits will be indexed to increase yearly in proportion to the Consumer Price Index. Employer contributions above these amounts will be included in the employee's income and taxed (income and Social Security) accordingly. Thus, individuals can choose to purchase as much health insurance as they wish with after-tax dollars, but the tax laws will not subsidize the purchase of unlimited health insurance.

Elaborate health benefits funded with tax-free, employer-paid contributions are inflationary—they insulate consumers, providers, and insurers from the cost consequences of health care decisions. By doing so, they contribute both to the persistence of inefficient forms of health care financing and delivery and to overuse of health services. The limit on tax-free benefits will help to alleviate these problems while allowing employers to provide adequate tax-free coverage to protect an employee against the serious financial consequences of illness. Employees will be free to purchase more comprehensive health care coverage with after-tax dollars.

The proposal will be effective on January 1, 1984, except with respect to collective bargaining agreements in effect on January 31, 1983,

which will not be subject to the new rules until the earlier of January 31, 1986, or the first date on which such agreement is reopened after January 31, 1983.

OPTIONAL MEDICARE VOUCHER

The provision of the Health Incentives Reform package that creates an opportunity for Medicare beneficiaries to enroll in alternative health plans is contained in the "Medicare Voucher Act of 1983."

Last year Congress, with the support of my Administration, amended the Medicare statute to permit payments on a risk basis to HMOs and other competitive medical plans that provide Medicare beneficiaries with coverage at least as extensive as the Medicare benefit package. The optional voucher provision will build on current law by allowing Medicare beneficiaries to use Medicare benefits to enroll in a wider array of private health plans. Medicare will contribute an amount equal to 95 percent of what it would have cost to care for the beneficiary if he or she had elected traditional Medicare coverage. If a beneficiary selects a private health plan with a premium lower than Medicare's contribution, the beneficiary will be eligible for a cash rebate from the private plan. If, on the other hand, the private plan costs more than Medicare's contribution, the beneficiary must pay the difference.

Enrollment in a private health plan will be voluntary. Once a year, beneficiaries will have the opportunity to switch private health plans or to elect traditional Medicare coverage. A qualified health plan may be an HMO, an indemnity insurer, or a service benefit plan. All private plans must cover, at a minimum, the services provided under Parts A and B of Medicare, and must participate in a coordinated annual open enrollment period.

MEDICARE PHYSICIAN PAYMENT FREEZE AND HOSPITAL REIMBURSEMENT LIMITS

The other provisions of this package are contained in the "Health Care Financing Amendments of 1983."

Medicare customary and prevailing charges for physician services will be held at 1983 levels for one year beginning in July 1984. Under current law prevailing charges would otherwise be increased in July 1984 by the annualized 1984 value of the Medicare Economic Index while increases in customary charges would not be constrained. This limit is consistent with other steps contained in the Budget to reduce the structural deficit.

The Tax Equity and Fiscal Responsibility Act (TEFRA) limited the increase in hospital expenditures under Medicare to the increase in the cost of goods and services hospitals purchase (the hospital "market basket index") plus one percent. This provision amends TEFRA to limit the rate of increase in hospital expenditures for fiscal year 1984 only to the increase in the hospital market basket index.

These proposals are part of a government-wide freeze aimed at reducing the Federal deficit. Medicare spending for physicians increased by 21 percent in 1982 and is expected to rise by 19 percent in 1983 and 17 percent in 1984. As mentioned earlier, Medicare hospital

expenditures have grown at comparable rates. In this time of fiscal crisis, we must ask all participants in the health care market, physicians, hospitals, and program beneficiaries, to do their part in slowing increases in spending.

GRADUATED INCREASES IN THE SUPPLEMENTARY MEDICAL INSURANCE (SMI) OR PART B PREMIUM

This provision will freeze the Part B premium at the present $12.20 per month for the remainder of 1983, instead of increasing it to $13.50 in July as was previously announced. The delay coincides with the delay in the cost-of-living increase for Social Security recommended by the National Commission on Social Security.

In January 1984, the Part B premium will be set at 25 percent—the percentage specified in current law—of program costs for aged beneficiaries for that calendar year. Over the next four years, the Part B premium will be increased 2.5 percentage points each year, to reach 35 percent of program costs for the elderly in January 1988. Thereafter, the premium for each calendar year would be set at 35 percent of program costs (the actuarially adequate rate) for the elderly for that year. When Medicare, began, Congress envisioned that the elderly would bear 50 percent of SMI costs and the law initially required that SMI costs be equally financed by the general taxpayer and the users of SMI services.

By gradually raising the SMI premium to 35 percent of program costs, this provision provides for a more equitable balance between general revenue and premium financing of Medicare Part B.

INDEXING THE PART B DEDUCTIBLE

The Part B deductible will be increased in January of each year based on annual changes in the Medicare Economic Index. This provision would maintain the constant dollar value of the deductible.

The 1981 Reconciliation Act increased the Part B deductible from $60 to $75. Before this amendment, the deductible had remained at $60 since 1972, despite a 250 percent increase in program reimbursements per aged enrollee between 1972 and 1981.

Current law does not provide for future increases in the deductible. As a result, the initial beneficiary liability for medical services will decrease in real terms over time and these costs will be shifted to the Federal government. Furthermore, the value of the deductible as a deterrent to unnecessary utilization will again diminish.

OTHER PROPOSALS

The legislation I am submitting today includes other items, all of which are designed to make Medicare and Medicaid more effective and efficient programs. They include, among others, proposals for competitive purchasing for laboratory services and durable medical equipment and reimbursement charges for certain Medicare services.

NOMINAL MEDICAID COPAYMENTS

This provision requires States to impose nominal copayments on all Medicaid beneficiaries for hospital, physician, clinic, and outpatient

department services. Specifically, the categorically needy would have to pay $1 per day for hospital services and $1 per visit for physician or outpatient services. The medically needy would have to pay $2 per day for hospital services and $1.50 per visit for physician services. Beneficiaries who are enrolled in HMOs or who are institutionalized would be exempt from all copayment requirements.

First-dollar insurance coverage, such as that which Medicaid provides, leaves the consumer with virtually no financial incentive to question the need for services. Services that are totally free are likely to be overutilized. If patients share in some of the costs, they and their physicians will reduce unnecessary or marginal utilization. There is substantial evidence that cost-sharing can reduce health care costs, mostly by reducing unnecessary utilization.

BUDGETARY EFFECT OF THE HEALTH INCENTIVES REFORM PACKAGE AND OTHER MEDICARE AND MEDICAID PROVISIONS

These provisions will have a substantial impact on reducing the size of the Federal budget and the Federal deficit. In fiscal year 1984 this legislative package will have a cumulative budgetary impact of $4.2 billion: the net Medicare impact of spending reductions and premium increases is a budgetary reduction of $1.7 billion; Federal Medicaid spending reductions amount to $256 million, and increased tax revenues from the change in the tax treatment of employer-paid health benefits amount to $2.3 billion. These savings are sustained and, in fact, grow in subsequent years.

The legislation that we are advancing today reflects our most thoughtful effort to address and reform the basic economic incentives that operate in the health care sector. Since health care now represents over 10 percent of our Nation's Gross National Product and is growing as a proportion of GNP each year, the enormous task of structural reform is well worth undertaking. As I mentioned earlier, we have taken great care to devise a legislative package that shares the responsibility for such reform and the burden of reductions in health care financing fairly among all segments of our society. The distribution of budgetary savings among workers and Medicare and Medicaid beneficiaries confirms our efforts in this regard.

Our need to constrain the growth of our national spending for health care in the interests of a healthy and stable economy is urgent. Regulatory approaches to health care cost containment tried previously have proven ineffective and sometimes counterproductive to this goal. I urge you to join me in facing the challenge before us and consider favorably our approach to health incentives reform.

RONALD REAGAN.

THE WHITE HOUSE, *February 28, 1983.*

SUMMARY OF PROPOSED MEDICARE CATASTROPHIC HOSPITAL COST PROTECTION ACT

Section 1 would assign the draft bill the short title "Medicare Catastrophic Hospital Cost Protection Act".

Section 2 would restructure benefits under the Medicare Hospital Insurance program. Under current law, Medicare covers only the first 90 days of a hospitalization during any spell of illness, plus a lifetime reserve of 60 additional days. An inpatient hospital deductible is imposed for each spell of illness. No coinsurance is currently imposed for the first 60 days of a spell of illness; coninsurance equal to one-fourth of the inpatient hospital deductible is imposed for each additional day of hospitalization through the 90th day; and coinsurance equal to one-half of the inpatient hospital deductible is imposed for any remaining days covered by Medicare.

Section 2 would remove the limit on the number of days of hospitalization covered by Medicare during a spell of illness. In addition, no more than two inpatient hospital deductibles could be imposed during any calendar year, even if there were three or more spells of illness in the year. Coinsurance equal to 8 percent of the inpatient hospital deductible would be imposed for the second through fifteenth day of each spell of illness (and for the first day if no inpatient hospital deductible were imposed for that spell of illness), and coinsurance equal to 5 percent of the inpatient hospital deductible would be imposed for each subsequent day; in any calendar year, however, the total number of days for which coinsurance was imposed, plus the number of times the inpatient hospital deductible was imposed, could not exceed 60.

Finally, section 2 would decrease from 12.5 to 5 percent of the inpatient hospital deductible the coinsurance imposed on the 21st through 100th day of care in a skilled nursing facility during any spell of illness.

A B I L L

To restructure the Medicare Hospital Insurance program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled,

Short Title and References in Act

Section 1. (a) This Act may be cited as the "Medicare Catastrophic Hospital Cost Protection Act".

(b) The amendments in this Act apply to the Social Security Act.

Restructuring of Medicare Hospital Insurance Program

Sec. 2. (a)(1) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended to read as follows:

"(1) inpatient hospital services;".

(2) Section 1812(b) (42 U.S.C. 1395d(b)) is amended --

(A) by striking out paragraph (1), and

(B) by renumbering paragraphs (2) and (3) as (1) and (2), respectively.

(3) Section 1812(c) (42 U.S.C. 1395d(c)) is amended to read as follows:

"(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, his entitlement to have payments made under this part on his behalf or to him for (1) inpatient psychiatric hospital services, or (2) inpatient hospital services when he is an inpatient primarily for the diagnosis or treatment of mental illness shall be limited during that first spell of illness to 150 days of such services

reduced by the number of days on which he was an inpatient of a psychiatric hospital during the 150 day period immediately before that first day.".

(b)(1) The first sentence of section 1813(a)(1) (42 U.S.C. 1395e(a)(1)) is amended by inserting ", and except that only two such reductions may be made in any calendar year" before the period.

(2) Subparagraphs (A) and (B) of the second sentence of section 1813(a)(1) (42 U.S.C. 1395e(a)(1)) are amended to read as follows:

"(A) eight percent of the inpatient hospital deductible for each of the first 15 days on which the individual is furnished such services during the spell of illness (other than the first day if the amount payable during the spell of illness is reduced by a deduction under the first sentence of this paragraph); and

."(B) five percent of the inpatient hospital deductible for each subsequent day on which the individual is furnished such services during the spell of illness;".

(3) The matter in the second sentence of section 1813(a)(1) (42 U.S.C. 1395e(a)(1)) following subparagraph (B) is amended by inserting ", and except that the sum of the number of days in a calendar year for which a reduction is made under this sentence and the number of times a reduction is made in that calendar year under the first sentence of this paragraph may not exceed 60" before the period.

(c) Section 1813(a)(3) (42 U.S.C. 1395e(a)(3)) is amended by striking out "one-eighth" and inserting instead "five percent".

(d) The amendments made by the preceding subsections apply to services furnished after 1983 (including services furnished after 1983 during a spell of illness that began before 1984).

LIMITATION ON EXCLUSION FOR EMPLOYER HEALTH PLAN PAYMENTS

General Explanation

Current Law

All employer contributions to health insurance plans for employees are excluded from the employees' income and wages for purposes of income and employment taxes. This tax treatment generally applies to all insurance coverage, regardless of cost, and to all medical benefits, no matter how extensive. The same rule generally applies to amounts paid by an employer to or on behalf of an employee under a self-insured medical plan.

Reasons for Change

Excluding employer contributions to health plans from gross income creates an inequity between individuals covered by employer health plans and those who are not so covered. The latter group must pay for their health care with after tax dollars, while the health care of the former group is provided with before tax dollars. For example, an employee with $23,000 of total compensation consisting of $20,000 of cash wages and $3,000 of health insurance coverage will pay $804 less in Federal income and Social Security taxes than one with $23,000 of cash wages.

The preferential treatment of employer paid health benefits encourages employees to receive large amounts of their compensation in that form. This has led to a significant decline in the amount of compensation subject to tax and indirectly has led to higher tax rates on cash wages.

From a health policy viewpoint, many employees have such generous insurance plans that they bear very little, if any, of the cost of doctors' visits or hospital services. They therefore tend to overuse doctor and hospital services and medical tests. The very rapid increase in health care costs in recent years can be attributed at least in part to this tax-induced incentive to demand additional health care with little or no regard to its actual costs.

Proposal

Employer contributions to a health plan would be includible in gross income to the extent that they exceed $70 per month ($840 per year) for an individual employee, or $175 per month ($2,100 per year) for family coverage.

The proposal will generally be effective January 1, 1984. However, in order to allow renegotiation of existing contracts, the proposal will not be effective with respect to employer contributions to employer health plans, the amounts of which are fixed by a legally binding contract entered into on or before January 31, 1983, until the earlier of January 31, 1986, or the first date after January 31, 1983 on which such amounts cease to be fixed by the contract.

Effects of Proposal

The amount of employer contributions is determined, in the case of an insured plan, on the basis of the premiums charged for such insurance. The insurance premiums paid by the employer on behalf of employees will be divided by the number of covered employees. If the employer maintains different plans covering different groups of employees, each plan will be treated separately in determining employer costs per employee.

In the case of noninsured plans, the amount of the employer contributions will be based on the costs of providing coverage under the plan. Costs of providing coverage may be determined based on reasonable estimates of such costs.

To the extent that employer contributions exceed the $70 individual/$175 family monthly ceilings, the excess would be includible in the income of the covered employee. Even if employer health plan payments exceed the $70 individual/$175 family monthly amounts, only the excess will be included in the employee's gross income. For example, if the employer paid $185 per month for family health coverage for an employee, $10 per month would be included in the employee's gross income. Thus, $10 would be subject to income tax and FICA and FUTA taxes (if applicable). Most current employees will pay no additional tax because those employees have insurance coverage costing less than the applicable ceiling amount.

Revenue Estimate

Fiscal Years				
1984	1985	1986	1987	1988
$ (billions)				
2.1	4.2	6.0	8.0	10.7

LIMITATION ON EXCLUSION FOR EMPLOYER HEALTH PLAN PAYMENTS

Technical Explanation

Summary of the Proposal

Employer contributions to a health plan would be includible in gross income to the extent that they exceed $70 per month ($840 per year) for an individual employee, or $175 per month ($2100 per year) for family coverage.

Detailed Description

Under the proposal, the amount of any excess employer contributions to a health plan with respect to coverage of an employee during the payroll period will be included in the employee's gross income. Employer contributions for a payroll period are excess employer contributions to the extent they exceed the monthly dollar limit for such employee, prorated to reflect the length of the payroll period. For 1984, the monthly dollar limit is $70 for an employee with individual coverage under the plan and $175 for an employee with family coverage under the plan. For years after 1984, the monthly dollar limit will be adjusted to reflect changes in the Consumer Price Index. An employee will be treated as having individual coverage unless the employee has a spouse or a dependent who is covered under the plan.

The employer contribution to a health plan with respect to an employee will be the cost of coverage of the employee under the plan reduced by the amount of the employee's contributions for such coverage. The annual cost of coverage with respect to an employee will be the aggregate annual cost of providing coverage for all employees with the same type of coverage (individual or family) under the plan as that of the employee, divided by the number of such employees. The cost of coverage with respect to an employee for a payroll period will be the annual cost of coverage prorated to reflect the length of the payroll period. Any cost of providing coverage under a plan which is allocable to workmen's compensation or to a purpose other than providing medical care is not taken into account in determining the cost of coverage under the plan.

The annual cost of providing coverage under an insured plan (or any insured part of a plan) will be determined based on the net premium charged by the insurer for such coverage. The annual cost of providing coverage under a noninsured plan

17-039 O - 83 - 2

(or any noninsured part of a plan) will be based on the costs incurred with respect to the plan, including administrative costs. In lieu of using actual administrative costs, an employer may treat 7 percent of the plan's incurred liability for benefit payments as the administrative costs with respect to the plan. A plan will be a noninsured plan to the extent the risk under the plan is not shifted from the employer to an unrelated third party.

The cost of coverage under the plan must be determined in advance of the payroll period and must be redetermined not less often than once every 12 months. The cost of coverage must be redetermined whenever there are significant changes in the coverage provided under the plan or in the composition of the group of covered employees. The cost of coverage is determined separately for each separate plan of the employer. Coverage of a group of employees is a separate plan if such coverage differs from the coverage of another group of employees. Where the actual cost of coverage cannot be determined in advance, reasonable estimates of the expected cost of coverage are to be used. Where the cost of coverage fluctuates each year depending on the experience of the employer under the plan, an average annual cost of coverage will be used.

If an estimate is determined not to be a reasonable estimate, the employer will be liable for the income taxes (at the maximum rate applicable to individuals) and the employment taxes (both the employer's and the employee's share) that would have been imposed on the additional amount that would have been included in the income of employees as excess employer contributions if the actual cost of coverage had been used to determine the amount of excess employer contributions.

In the case of multiemployer plans to which an employer makes contributions, the multiemployer plan is to be treated as the employer for purposes of determining the cost of coverage and the liability for errors in estimates of the cost of coverage. Each employee's excess employer contributions will be determined based on this cost of coverage. However, for purposes of the employer's obligations to withhold from wages and to pay employment taxes, the amount of excess employer contributions will be considered to be a portion of each contribution made by the employer to the plan. The portion of each contribution to be treated as an excess employer contribution will be based on the ratio of the plan's excess employer contributions per employee per month to the total monthly employer contribution per employee.

Effective Date

In general, the proposal would apply to employer contributions made with respect to payroll periods beginning after December 31, 1983. However, the proposal will not apply to employer contributions to employer health plans, the amounts of which are fixed by a legally binding contract entered into on or before January 31, 1983, until the earlier of January 31, 1986, or the first date after January 31, 1983 on which such amounts cease to be fixed by the contract.

A BILL

To amend the Internal Revenue Code of 1954 to provide for the inclusion of certain employer contributions to health plans in an employee's gross income.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE

This Act may be cited as the "Health Cost Containment Tax Act of 1983."

SEC. 2. CERTAIN EMPLOYER HEALTH PLAN CONTRIBUTIONS INCLUDED IN INCOME.

(a) Inclusion in Income.--

(1) In general.--Part II of subchapter B of chapter 1 (relating to items specifically included in gross income) is amended by adding at the end thereof the following new section:

"SEC. 87. EXCESS EMPLOYER CONTRIBUTIONS TO HEALTH PLANS.

"(a) General Rule.--

"(1) Inclusion in income.--If an employee is covered by an employer health plan at any time during a payroll period and there is an excess employer contribution to such plan with respect to coverage of the employee during such payroll period, then an amount

equal to such excess employer contribution shall be included in the gross income of the employee for such payroll period.

"(2) Treatment of amount included.--For purposes of this title, any amount included under paragraph (1) in an employee's gross income for a payroll period shall be treated as compensation paid to the employee in cash on the earliest date on which any other compensation for such payroll period is paid to the employee or included in the employee's gross income.

"(b) Excess Employer Contribution.--

"(1) In general.--For purposes of this section, the term 'excess employer contribution' means, with respect to coverage of an employee during a payroll period, the excess of--

"(A) the employer contributions made by a single employer to one or more plans with respect to coverage of the employee during the payroll period, over

"(B) the applicable monthly dollar limit for coverage of such employee multiplied by a fraction, the numerator of which is 12 and the denominator of which is the number of payroll periods in a calendar year.

"(2) Special Rule for Multiemployer Plans.--If an employer makes contributions with respect to an employee for a payroll period to a health plan which is, or is part of, a multiemployer plan, then solely for purposes of the employer's obligations under subtitle C, the

excess employer contribution shall be considered to be an amount equal to the employer's actual contributions to the plan multiplied by a fraction, the numerator of which is the excess employer contributions, determined as provided in paragraph (1), for one month with respect to coverage of all employees under the plan, and the denominator of which is the total monthly employer contributions, determined as provided in subsection (d), for one month with respect to coverage of all employees under the plan. For purposes of this paragraph only, the excess employer contributions under the plan may be determined on the basis of a single cost of coverage for both individual and family coverage (as provided in subsection (e)(1)) and a single monthly dollar limit (as provided in subsection (c)(3)).

"(c) Monthly Dollar Limits.--

"(1) Monthly dollar limits for 1984.--The applicable monthly dollar limit for coverage of an employee during any payroll period beginning in calendar year 1984 shall be--

"(A) $70 for coverage of an individual employee, or

"(B) $175 for coverage of an employee and one or more members of the employee's family.

"(2) Monthly dollar limits for years after 1984.--The monthly dollar limits for coverage of an employee during any payroll period beginning in a

calendar year after 1984 shall be the monthly dollar limit provided in paragraph (1) multiplied by a fraction, the numerator of which is the Consumer Price Index for the 12-month period ended June 30 of the calendar year immediately preceding the calendar year in which the payroll period begins, and the denominator of which is the Consumer Price Index for the 12-month period ended June 30, 1983. Each monthly dollar limit so determined shall be rounded to the nearest whole dollar. For purposes of this paragraph, the Consumer Price Index for a 12-month period shall mean the average of the Consumer Price Indexes for All Urban Consumers published by the Department of Labor for each month in the 12-month period.

"(3) Single monthly dollar limit.--In the case of a health plan which is, or is part of, a multiemployer plan, the multiemployer plan may apply a single dollar limit to coverage of all employees under the plan for purposes of applying the special rule in subsection (b)(2). The single monthly dollar limit shall be a weighted average determined, in the manner prescribed by the Secretary in regulations, based on the applicable monthly dollar limits provided in paragraph (1) or (2) and the percentage of employees having each type of coverage.

"(d) Employer Contributions.--The employer contributions to any health plan with respect to coverage of an employee for a payroll period shall be the cost of coverage of the employee for such payroll period reduced by any contributions made by the employee for such coverage.

"(e) Cost of Coverage.--

"(1) Cost per employee.--The cost of coverage shall be determined separately for individual coverage and family coverage under each plan of the employer, except that for purposes of applying the special rule in subsection (b) (2), a single cost of coverage may be determined for individual and family coverage. Such single cost of coverage shall be a weighted average determined, in the manner prescribed by the Secretary in regulations, based on the cost of coverage for each type of coverage separately and the percentage of employees having each type of coverage. The annual cost of coverage of an employee shall be determined by dividing the aggregate annual cost of providing coverage for all employees who are covered under the plan and who have the same type of coverage (individual or family) as the employee, by the number of such employees. In making such determination, amounts shall be taken into account with respect to any employee only for periods during which such employee is covered by the plan. The cost of coverage of an employee for a payroll period shall be the annual cost of coverage for the employee multiplied

by a fraction, the numerator of which is 1 and the denominator of which is the number of payroll periods in a calendar year.

"(2) Time for determining cost of coverage.--The cost of coverage under a plan for a payroll period shall be determined prior to the beginning of the payroll period and shall be redetermined not less often than once every 12 months. The cost of coverage shall be redetermined whenever there are significant changes in coverage or in the composition of the group of employees covered.

"(3) Determination of cost of coverage.--The annual cost of providing coverage under a plan shall be based on the cost to the employer of insurance for any insured coverage under the plan, plus all costs incurred with respect to noninsured coverage under the plan. Where the cost to the employer of insurance reflects the employer's prior experience under the plan, an average cost of such insurance, based on premiums for the three immediately preceding years (adjusted to reflect changes in the cost of health insurance), may be used. The cost of providing noninsured coverage shall equal the liability incurred for benefit payments under the plan plus all other costs, including administrative costs, incurred with respect to the plan. In lieu of determining the actual amount of other costs (costs other than the liability incurred for benefit payments),

an employer may treat an amount equal to 7 percent of the liability incurred for benefit payments as equal to such other costs. In the case of a health plan that is, or is part of, a multiemployer plan, the cost of coverage under the plan shall be determined as if the multiemployer plan were the employer.

"(4) Estimation of costs.--Where the actual cost of providing coverage cannot be determined in advance, the cost of coverage shall be based on a reasonable estimate that takes into account such factors as the Secretary may prescribe in regulations.

"(5) Estimate not reasonable.--If the cost of coverage under a plan for any payroll period is determined on the basis of estimates, and such estimates are determined not to be reasonable, then the employer or, in the case of a plan which is, or is part of, a multiemployer plan, the multiemployer plan shall be liable for the taxes that would have been imposed under this title with respect to all employees on the amount by which the excess employer contribution for each employee, determined on the basis of the actual cost of coverage, exceeds the amount of such excess employer contribution, determined on the basis of the estimated cost of coverage, if such excess amount had been included, for the calendar year in which the payroll period begins, in the taxable income of each employee and --

"(A) each employee was subject to the maximum rate of tax imposed on individuals under section 1,

"(B) the remuneration of each employee for employment (including such excess) for the calendar year did not exceed the contribution and benefit base amount for such year (as determined under section 230 of the Social Security Act), and

"(C) the remuneration of each employee for employment (excluding such excess) for the calendar year exceeded $6,000.

"(7) Amounts not for medical care.--Any cost of providing coverage under a plan which is properly allocable to--

"(A) workmen's compensation, or

"(B) a purpose other than the providing of medical care,

shall not be taken into account in determining the cost of coverage for purposes of this section.

"(g) Individual coverage.--In any case where an employee has coverage other than individual coverage, and the employee has no spouse or dependent who is actually covered by reason of the employee's coverage, then the employee must notify the employer (or the multiemployer plan in the case of a plan which is, or is part of, a multiemployer plan) of such fact. Such an employee shall be treated for all purposes under this section as having individual coverage.

"(h) Information reports by multiemployer plans.-- Each multiemployer plan which includes an employer health plan with respect to which there are excess employer contributions for a calendar year must, prior to February 1 of the succeeding calendar year, provide an information report to each employee with respect to whom contributions to the plan were made during the calendar year. Such information report shall include the following:

"(1) The amount of the excess employer contributions with respect to the employee for such calendar year, and

"(2) The amount of employer contributions to the plan that were treated by employers under section 87(b)(2) as excess employer contributions included in the gross income of the employee.

"(i) Liability for overestimates.--No employer or multiemployer plan shall be subject to any liability by reason of a determination that the cost of coverage determined by the employer or the multiemployer plan exceeded the actual cost of coverage.

"(j) Definitions.--For purposes of this section--

"(1) Employer health plan.--The term 'employer health plan' means an arrangement to which the employer makes contributions to provide (directly or through insurance, reimbursement, or otherwise) medical care for employees and their families in the event of personal injury or sickness. The term 'employer health plan'

does not include any arrangement for the provision of medical care for individuals in active service in the Armed Forces of the United States or for the families of such individuals.

"(2) Separate plans.--

"(A) Different coverage for separate groups. -- If a group of one or more employees receives coverage which differs from the coverage received by a second group of one or more employees, each such group shall be treated as covered by a separate plan. Individuals whose primary health insurance coverage is coverage under Title XVIII of the Social Security Act shall be treated as receiving different coverage from individuals whose primary health insurance coverage is other than coverage under Title XVIII of the Social Security Act.

"(B) Employer determination. -- The determination of whether two groups of one or more employees receiving identical coverage shall each be treated as covered by a separate plan shall be made by the employer except as otherwise prescribed by the Secretary in regulations.

"(3) Employee.-- The term 'employee' does not include an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

"(4) Family.--The term 'family' means, with respect to an employee, the employee's spouse and any dependents of the employee.

"(5) Medical care.--The term 'medical care' has the meaning given such term by paragraph (1) of section 213 (e).

"(6) Noninsured coverage.--The term 'noninsured coverage' means any coverage, the risk of which is not shifted from the employer to an unrelated third party. All other coverage is insured coverage.

"(7) Multiemployer plan.--The term 'multiemployer plan' means an employee welfare benefit plan (within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974)--

"(A) to which more than one employer is required to contribute, and

"(B) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer."

"(8) Payroll period.--The term 'payroll period' has the meaning provided such term in section 3401(b).

"(9) Single employer.--The term 'single employer' shall mean a single employer determined under rules similar to the rules provided by subsections (b), (c), and (m) of section 414.

(2) The table of sections for part II of subchapter B of chapter 1 is amended by adding at the end thereof the following:

"Sec. 87. Excess employer contributions to health plans.".

(b) Exclusion from Income.--Section 106 is amended by striking the word "Gross" at the beginning thereof and inserting in lieu thereof the words "Except as provided in section 87 with respect to excess employer contributions, gross".

(c) Employment Tax Amendments.--

(1) Federal Insurance Contributions Act Amendments.--Section 3102 is amended by adding at the end thereof the following new subsection:

"(d) Special rule for excess employer contributions.--

"(1) In the case of excess employer contributions (within the meaning of section 87 (b)) which constitute wages, subsection (a) shall be applicable only to the extent that collection can be made by the employer, at or after the date on which such excess employer contributions are treated as paid to the employee under section 87 (a) (2) and before the close of the 30th day following such date, by deducting the amount of the tax from such wages of the employer (excluding excess employer contributions, but including funds turned over by the employee to the employer pursuant to paragraph (2)) as are under control of the employer.

"(2) If the tax imposed by section 3101, with respect to excess employer contributions (within the meaning of section 87 (b)), exceeds the wages of the employee (excluding excess employer contributions) from which the employer is required to collect the tax under paragraph (1), the employee may furnish to the employer, on or before the 30th day following the date on which the excess employer contributions are treated as paid to the employee under section 87 (a) (2), an amount of money equal to such excess.

"(3) If the tax imposed by section 3101 with respect to excess employer contributions which constitute wages exceeds the portion of such tax which can be collected by the employer from the wages of the employee pursuant to paragraph (1), such excess shall be paid by the employee."

(2) Railroad Retirement Tax Act Amendments.-- Section 3202 is amended by adding at the end thereof the following new subsection:

"(d) Special Rules for Excess Employer Contributions.--

"(1) In the case of excess employer contributions (within the meaning of section 87 (b)) which constitute wages, subsection (a) shall be applicable only to the extent that collection can be made by the employer, at or after the date on which such excess employer contributions are treated as paid to the employee under section 87 (a) (2) and before the close of the 30th day

following such date, by deducting the amount of the tax from such wages of the employee (excluding excess employer contributions, but including funds turned over by the employee to the employer pursuant to paragraph (2)) as are under control of the employer.

"(2) If the tax imposed by section 3201, with respect to excess employer contributions (within the meaning of section 87 (b)), exceeds the wages of the employee (excluding excess employer contributions) from which the employer is required to collect the tax under paragraph (1), the employee may furnish to the employer, on or before the 30th day following the date on which the excess employer contributions are treated as paid to the employee under section 87 (a) (2), an amount of money equal to such excess.

"(3) If the tax imposed by section 3201 with respect to excess employer contributions which constitute wages exceeds the portion of such tax which can be collected by the employer from the wages of the employee pursuant to paragraph (1), such excess shall be paid by the employee."

(3) Collection of Income Tax at Source Amendments. -- Section 3402 is amended by adding at the end thereof the following new subsection:

"(s) Excess Employer Contributions.--In the case of excess employer contributions (within the meaning of section 87 (b)) which constitute wages, subsection (a) shall be

applicable only to the extent that the tax can be deducted and withheld by the employer, at or after the date on which such excess employer contributions are treated as paid to the employee under section 87 (a) (2) and before the close of the calendar year in which such date occurs, from such wages of the employee (excluding excess employer contributions, but including funds turned over by the employee to the employer for the purpose of such deduction and withholding) as are under the control of the employer. Such tax shall not at any time be deducted and withheld in an amount which exceeds the aggregate of such wages and funds (including funds turned over under section 3102 (d) (2) or section 3202 (d) (2)) minus any tax required by section 3102 (a) or section 3202 (a) to be collected from such wages and funds."

(4) General rule.--Chapter 25 (relating to general provisions relating to employment taxes) is amended by adding at the end thereof the following new section:

"SEC. 3508. TREATMENT OF EXCESS EMPLOYER CONTRIBUTIONS.

"(a) For purposes of this subtitle, any amount required to be included in the gross income of an employee under section 87 (a) shall not be treated as a payment under a plan or system established by the employer on account of sickness or accident disability or medical or hospitalization expenses in connection with sickness or accident disability.

"(b) In the case of an employer who makes contributions to a health plan that is, or is part of, a multiemployer plan, then the amount of the excess employer contribution for

purposes of the employer's liabilities and obligations under sections 3102, 3111, 3202, 3221, 3301, and 3401 shall be the amount determined under section 87 (b) (2)."

(2) Clerical amendment.--The table of sections for chapter 25 is amended by adding at the end thereof the following new item:

"Sec. 3508. Treatment of excess employer contributions."

(c) Effective Dates.--

(1) In general.--Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to payroll periods beginning after December 31, 1983, in taxable years ending after such date.

(2) Employment taxes.--The amendments made by subsection (c) shall take effect January 1, 1984.

(3) Legally binding contracts.--The amendments made by this section shall not apply with respect to employer contributions to an employer health plan, the amounts of which are fixed by the terms of a legally binding contract in effect on January 31, 1983, prior to the earlier of January 31, 1986, or the first date on which the amounts of such employer contributions cease to be fixed by the terms of such a contract. For purposes of this paragraph the amounts of employer contributions cease to be fixed by the terms of a contract on the earliest of the date the contract terminates, the date the contract is extended, the date

the contract is reopened or renegotiated, the date any terms of the contract are altered, amended, or otherwise changed, or the date any party to the contract has a right to terminate either the entire contract or that portion of the contract relating to the employer health plan.

SUMMARY OF PROPOSED MEDICARE VOUCHER ACT OF 1983

Section 1 would assign the draft bill the short title "Medicare Voucher Act of 1983".

Section 2 would permit the Secretary to contract with health benefits organizations (HBOs) (a broad range of health insurers and health services providers, including health maintenance organizations (HMOs) and competitive medical plans (CMPs)) to provide private alternative coverage for Medicare beneficiaries (other than individuals suffering from end-stage renal disease, or who are working and are 65 years of age or older but under 70) who chose to participate in such a private plan. Section 2 would also enact additional amendments to current provisions of law concerned with Medicare contracts with such organizations to --

-- establish a single, coordinated open enrollment period during August and September of each year (but only for that number of new enrollees, in order of applications filed, previously specified by an HBO), and to enable the Secretary, to the extent feasible, to provide for individuals who move from the area served by one HBO to an area served by another (similar to the system used by the health benefits program for Federal employees),

-- preclude new enrollments for individuals receiving only Supplementary Medical Insurance (SMI) benefits,

-- preclude new cost-based contracts,

-- permit HBOs to offer separate benefit packages for employer-based groups,

-- permit HBOs to offer one or more benefit packages as long as each package covered at least those services for which Medicare pays and covered inpatient hospital services for every day of hospitalization, with benefit levels, coinsurance, and deductibles to be set by the HBO,

-- eliminate current requirements as to premium levels and benefits, and require only that the average cost-sharing for the portion of benefits for which Medicare pays not exceed the average cost-sharing (including amounts above the Medicare reasonable charge) under Medicare,

-- permit HBOs to provide annual rebates of up to $500 (instead of charging premiums), not consider those rebates as income for purposes of Medicaid, Aid to Families with Dependent Children, Supplemental Security Income, Food Stamps, Low-Income Home Energy Assistance, or low-income housing programs, and treat those rebates as

Social Security benefits for purposes of the Federal income tax laws, and

-- preempt provisions of State or local law requiring benefits more extensive that those under section 2.

Section 3 would enact conforming amendments that would --

-- repeal the requirment for the Secretary to conduct a study of additional benefits that are required under existing law (but not under the provisions of section 2), and

-- require payments to HBOs under section 2 to take into account services furnished by physician assistants or nurse practitioners if Medicare would pay for those services when furnished by a physician.

Section 4 would make the provisions of section 2 applicable to services furnished after 1984. Section 4 would also --

-- retain the transitional provisions enacted in 1982 when Congress amended the provisions of law providing for payments to HMOs,

-- permit any enrollee of an HMO or CMP at the end of 1984 not already covered by those earier transition provisions to continue his enrollment under the provisions of law then current if either the HMO or CMP had a cost-based contract with the Secretary or if the enrollee was enrolled for Medicare SMI (but not Hospital Insurance (HI) benefits), unless the Secretary found that the new provisions should apply to all members of an HMO or CMP because of administrative costs or other administrative burdens, and

-- apply the provisions of section 2 to enrollees who also receive benefits under Medicaid only after the Secretary finds that it is administratively feasible.

A B I L L

To provide for voluntary private alternative coverage for Medicare beneficiaries, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assemnbled,

Short Title

Section 1. This Act may be cited as the "Medicare Voucher Act of 1983".

Payments to Health Benefits Organizations

Sec. 2. Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended to read as follows:

"Payments to Health Benefits Organizations

"Sec. 1876. (a)(1) The Secretary shall annually determine a per capita rate of payment for each class of individuals who are enrolled under this section with a health benefits organization with which he has entered into a contract under subsection (i). The Secretary shall define appropriate classes of members, based on such factors as age, sex, disability status, and place of residence. The rate for each class shall be equal to 95 percent of the adjusted average per capita cost for that class. Each month the Secretary shall pay each such organization the appropriate rate, in advance, for the estimated number of individuals in each class enrolled under this section with the organization. The Secretary shall make appropriate retroactive adjustments for differences between estimated and actual enrollment. Payments under this paragraph shall be instead of the amounts that would be

otherwise payable under this title for services furnished to those individuals by any entity, except that amounts shall be payable by the Secretary as otherwise provided under this title for services furnished during any month for which the Secretary finds that the organization has substantially failed to meet the requirements of this section.

"(2) For purposes of this subsection, the term 'adjusted average per capita cost' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or actuarial equivalent based upon an adequate sample and other information and data) would be payable in any contract year for services covered under parts A and B, and types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by entities described in sections 1816 and 1842), if payment for the services (and, in the case of services covered only under section 1861(s)(2)(H), if the services were physicians' services or furnished as an incident to a physician's professional service) were to be made other than under this section.

"(3) The payment to a health benefits organization under this section for individuals enrolled under this section with the organization shall be made from the Federal Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of --

"(A) the product of (i) the number of such members for the month who have attained age 65, and (ii) 95 percent of the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(1), and

"(B) the product of (i) the number of such members for the month who have not attained age 65, and (ii) 95 percent of the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(4).

The remainder of that payment shall be paid by the former trust fund.

"(b) For purposes of this section --

"(1) the term 'health benefits organization' means a voluntary association, corporation, partnership, or other organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar arrangements, and includes a health benefits plan duly sponsored or underwritten by an employer or by an employee organization, and

"(2) the term 'employment based plan' means a plan under which --

"(A) a health benefits organization provides health benefits to at least all individuals residing in a geographic area who were employees of a

particular employer at age 65 or at a lower age specified in the plan (or, alternatively, had served as employees of that employer for at least 10 years or for a shorter minimum period specified in the plan), but who are not current employees,

"(B) the health benefits organization provides health benefits only to families of individuals who are or were employees of that employer, and

"(C) at least 25 percent of the premium (if any) for each employee or former employee is paid by the employer.

"(c) A health benefits organization --

"(1) shall provide, pay for, or reimburse the cost of, with such conditions as to amounts payable by the organization or by the individual as the organization may set (subject to the provisions of subsection (g)) --

"(A) at least all the services to which an individual enrolled under this section with the organization is entitled under this title that are available to other persons residing in the same geographic area as the individual, and

"(B) inpatient hospital services for every day on which the individual is a hospital inpatient,

"(2) shall provide the services to which the individual is entitled under this title through, or shall pay for, or reimburse the cost of, such services only if

furnished through, entities meeting the applicable requirements of section 1861,

"(3) shall provide, pay for, or reimburse the cost of, to the extent prescribed by the Secretary, services furnished on an emergency basis in any location (if they would be covered under this title in that location if the individual were not enrolled under this section with a health benefits organization),

"(4) shall provide for a sufficient number of entities to furnish services to which the individual is entitled under this title, and which the organization provides, pays for, or reimburses the cost of, in the geographic area in which the individual resides, so as to assure reasonable access to such services, and

"(5) may offer one or more combinations of benefits, as long as it offers to all individuals residing in a geographic area who are enrolled under this section with the organization under a particular employment based plan each combination of benefits that it offers to any such individual, and as long as it offers to all individuals residing in a geographic area who are enrolled under this section with the organization but not under an employment plan each combination of benefits that it offers to any such individual.

"(d) Subject to the provisions of subsection (e), every individual entitled to benefits under part A (other than an individual medically determined to have end-stage renal disease

or an individual to whom section 1862(b)(3) applies) shall be eligible to enroll under this section with any health benefits organization with which the Secretary has entered into a contract under subsection (i) that serves the geographic area in which the individual resides.

"(e)(1) The Secretary may prescribe the procedures and conditions under which a health benefits organization that has entered into a contract with the Secretary under this section (A) may inform individuals eligible to enroll under this section with the organization about the organization and (B) may enroll such individuals with (and disenroll them from) the organization.

"(2) An individual may apply for enrollment under this section with a health benefits organization --

"(A) as prescribed by the Secretary to enable the individual to be enrolled with the organization beginning with a month during which the individual is entitled to benefits under part A that follows a month during which the individual has not been so entitled,

"(B) as prescribed by the Secretary (to the extent that the Secretary finds it feasible) to enable the individual to be enrolled with the organization beginning with a month during which he no longer resides in the geographic area served by another health benefits organization with which he was enrolled in the previous month, and

"(C) during August and September of each year.

"(3) An individual enrolled with a health benefits organization under this section shall thereby be enrolled in, covered by, and subject to the premium of, the program under part B.

"(4) An individual may apply to disenroll under this section from a health benefits organization during August and September of each year.

"(5) The enrollment (or disenrollment) under this section of an individual who applies for enrollment under paragraph (2)(B) (or for disenrollment under paragraph (4)) shall be effective as of the following January.

"(6) An individual may apply to disenroll under this section from a health benefits organization during any month in which he no longer resides in the geographic area that the organization serves (or during the month preceding such a month). Disenrollment under this paragraph shall be effective as of the month following the month of application.

"(7) Any individual enrolled with a health benefits organization under this section who fails to pay for three consecutive months the premium required by the organization shall be disenrolled as of the fourth month.

"(8) Any individual enrolled with a health benefits organization under this section shall be disenrolled as of any month during which he is no longer entitled to benefits under part A or is no longer entitled to benefits under part B.

"(9) A health benefits organization may not expel or refuse to re-enroll any individual enrolled with the

organization because of the individual's health status or requirements for health benefits, and shall so notify each such individual at the time of the individual's enrollment.

"(10) Any individual who ceases to be enrolled under this section with a health benefits organization but who remains entitled to benefits under part A or part B of this title shall be entitled to those benefits as prescribed other than under this section.

"(11) A health benefits organization may refuse to accept the enrollment of an eligible individual under this section with the organization only if the organization accepts enrollments in order of application and --

"(A) the organization provides health benefits in a geographic area only under employment based plans and an applicant for enrollment residing in that geographic area is not eligible to participate in one of those plans,

"(B) the enrollment of the individual would result in a total new enrollment under this section in a calendar year exceeding a number that the organization had transmitted to the Secretary by the time specified by the Secretary (but not later than June of the preceding year),

"(C) the enrollment of the individual would result in the organization's failing to meet the requirement of subsection (h), or

"(D) the individual was disenrolled from a health benefits organization under paragraph (7) during the

twelve month period preceding the month in which the individual has applied for enrollment.

"(f) Any individual enrolled with a health benefits organization under this section who is dissatisfied by reason of his failure to receive any health benefit to which he believes he is entitled shall, if the amount in controversy is at least the minimum amount specified in section 1869(b) that entitles an individual to a hearing on a determination as to benefits under part A, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the health benefits organization a party. If the amount in controversy is at least the minimum amount specified in section 1869(b) that entitles an individual to judicial review of a determination as to benefits under part A, the individual or health benefits organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the health benefits organization shall be entitled to be parties to that judicial review.

"(g)(1) The actuarial value of the amounts (other than premiums) that an individual enrolled under this section with a health benefits organization is required to pay for services furnished in any calendar year that are covered under this title may not exceed the actuarial value of the amounts (other than premiums) that the individual would be required to pay for

those services if the individual were not enrolled with a health benefits organization under this section.

"(2) The organization may charge each individual enrolled under this section with the organization a premium set by the organization, but the premium rate for any particular combination of benefits for all individuals residing in a geographic area who are enrolled under a particular employment based plan shall be the same during a calendar year, and the premium rate for any particular combination of benefits for all individuals residing in a geographic area who are not enrolled under an employment based plan shall be the same during a calendar year. The organization may provide rebates, subject to the condition prescribed by the preceding sentence, instead of charging premiums. Rebates may not exceed $500 per individual for any calendar year. Rebates shall not be considered income for purposes of title I, IV, X, XIV, XVI, or XIX, the Food Stamp Act of 1977, the Low-Income Home Energy Assistance Act of 1981, or the United States Housing Act of 1937. Rebates shall be treated as benefits under title II for purposes of subtitle A of the Internal Revenue Code of 1954.

"(3) The health benefits organization may, in the case of services furnished to an individual enrolled with the organization under this section for an illness or injury for which the individual is entitled to benefits under a workmens' compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance, charge or

authorize the entity furnishing the services to charge, in accordance with the charges allowed under that law, plan, or policy --

"(A) the entity which under that law, plan, or policy is to pay for the provision of those services, or

"(B) the individual, to the extent that he has been paid under that law, plan, or policy for those services.

"(h)(1) Except as otherwise provided in paragraph (2), each health benefits organization with which the Secretary enters into a contract under this section shall, in any geographic area, provide health benefits to at least one individual who is neither entitled to benefits under this title nor entitled to benefits under a State plan approved under title XIX for each individual entitled to benefits under this title or under such a State Plan to whom the organization provides health benefits.

"(2) The Secretary may modify or waive the requirement imposed by paragraph (1) if the Secretary determines that --

"(A) special circumstances warrant a modification or waiver, and

"(B) the organization has taken and is making reasonable efforts to provide health benefits to individuals who are neither entitled to benefits under this title nor entitled to benefits under a State plan approved under title XIX.

"(i)(1) The Secretary shall enter into a contract with any health benefits organization that agrees to meet, and that

the Secretary finds will meet, the requirements of this section.

"(2) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health benefits organization involved as he may provide in regulations) if he finds that the organization has substantially failed to meet the requirements of this section.

"(3) The effective date of any contract executed pursuant to this subsection shall be specified in the contract.

"(4) Each contract under this section --

"(A) shall provide that the Secretary --

"(i) shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and

"(ii) shall have the right to audit and inspect any books and records of the health benefits organization that pertain to services performed or determinations of amounts payable under the contract,

"(B) shall require the health benefits organization to provide such information to the Secretary as he may request,

"(C) shall require the health benefits organization to provide (and pay for) written notice in advance of the contract's termination, and

"(D) shall require the organization to meet such other conditions as the Secretary may find are needed to carry out effectively the provisions of this section.

"(5) The Secretary may not enter into a contract with a health benefits organization under this subsection if more than one former contract with that organization under this subsection was terminated at the request of the organization within the preceding five year period, except in circumstances which the Secretary finds warrant special consideration.

"(6) Any claim of the United States against a health benefits organization shall have priority over any claim of any other entity against the organization.

"(j) The functions vested in the Secretary by subsection (i) may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.".

"(k) The provisions of this section preempt any State or local law or regulation that requires benefits more extensive than the minimum benefits specified in paragraphs (1) and (3) of subsection (c).".

Conforming Amendments

Sec. 3. (a) Section 114(d) of the Tax Equity and Fiscal Responsibility Act of 1982 (42 U.S.C. 1395mm nt.) is repealed.

(b) Section 1861(s)(2)(H) of the Social Security Act (42 U.S.C. 1395x(s)(2)(H)) is amended by striking out "to a member of an eligible organization" and "to such a member".

Effective Date and Transitional Provisions

Sec. 4. The amendments made by section 2 apply with respect to services furnished after 1984, but shall not apply --

(1) for the periods and under the conditions specified in section 114(c) of the Tax Equity and Fiscal Responsibility Act of 1982 (42 U.S.C. 1395mm nt.),

(2) to any individual who at the end of 1984 is enrolled with a health maintenance organization or competitive medical plan with which the Secretary has entered into an agreement under section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)) or to any other individual who at the end of 1984 is not enrolled in the program under part A of title XVIII of that Act but is enrolled with a health maintenance organization or competitive medical plan under section 1876 of that Act (42 U.S.C. 1395mm) (or with such an organization to which section 114(c)(1)(B) of the Tax Equity and Fiscal Responsibility Act of 1982 (42 U.S.C. 1395mm nt.) applies), unless --

(A) the individual requests at or after that time that the amendments apply, or

(B) the Secretary determines at any time that the amendments should apply to all members of the organization because of administrative costs or other administrative burdens involved and so informs in advance each affected member of the organization, or

(3) with respect to services furnished to any individual receiving benefits under a plan of a State approved under title XIX of the Social Security Act (unless the services are furnished by an entity that has furnished services to such individuals under section 1876 of that Act (42 U.S.C. 1395mm) before 1985) until the Secretary finds that it is administratively feasible for the amendments to apply.

SUMMARY OF PROPOSED HEALTH CARE
FINANCING AMENDMENTS OF 1983

Short Title and References in Act

Section 1 would assign the draft bill the short title "Health Care Financing Amendments of 1983".

TITLE I - MEDICARE

Subtitle A - Changes in Eligibility, Benefits, and Cost Sharing

Use of Medicare Physicians' Services Economic Index to Increase Annually the Supplementary Medical Insurance Deductible

Section 101 would increase the Supplementary Medical Insurance (SMI) deductible (currently set at $75) each year, beginning with 1984, by the percentage increase in the economic index used to determine the allowable increase in prevailing charges for physicians' services. This section would allow the SMI deductible to keep pace with changes in physician fees in the future.

First Full Month of Medicare Eligibility

Section 102 would provide for eligibility for Medicare benefits to begin in the first full month in which all the eligibility requirements have been met.

Changes in Supplementary Medical Insurance Premium

Section 103 would postpone from July 1983 until January 1984 (along with the Administration's proposed postponement of cost-of-living adjustments in Social Security benefits) the increase in the SMI premium. In January of 1984 the premium would rise to 25 percent of the estimated per capita costs of the SMI program for the aged for 1984. For each succeeding year the percentage of the estimated program costs covered by the premium would increase by increments of 2.5 percent until 35 percent of the estimated costs were covered by the premium for 1988. No beneficiary, however, for whom SMI premiums were deducted from his Social Security benefits would have his Social Security check reduced below its amount before the most recent Social Security cost of living adjustment because of the SMI premium increase. These changes would provide a more reasonable balance between Federal and beneficiary shares of total program costs, which were originally intended to be evenly shared.

Cost Sharing for Durable Medical Equipment Furnished as a Home Health Benefit

Section 104 would provide for a Medicare beneficiary to share the costs of durable medical equipment furnished as a home health benefit. Under current law, Medicare pays 80 percent of the reasonable charges for durable medical equipment furnished as a separate benefit, but pays 100 percent of the reasonable cost if the equipment is furnished as a home health benefit. Section 104 would reduce the Medicare payment for durable medical equipment furnished as a home health benefit to the lesser of the reasonable cost and the customary charges (less 20 percent of the reasonable charges, which a home health agency would be permitted to collect from the beneficiary), but in no event more than 80 percent of the reasonable cost. This amount is the same amount that a provider of services is paid for medical and other health services under Medicare. The Secretary could also, as is the case with other provisions requiring payment of the lesser of costs or charges, take only costs (and not charges) into account if he found that this would not result in any increase in Medicare payments. Section 104 would also permit the Secretary to require the purchase, rather than the rental, of durable medical equipment under appropriate circumstances, whether or not furnished as home health benefits, and would provide for the uniform use of the term "durable medical equipment" instead of the use of three different terms currently employed in various Medicare provisions.

Elimination of Deductible for Diagnostic Tests Performed in a Laboratory Which has Entered into A Negotiated Rate Agreement with the Secretary

Section 105 would eliminate the application of the SMI annual deductible to diagnostic tests performed in a labortory which has entered into a negotiated rate agreement with the Secretary. The section would provide an incentive for laboratories to enter into such agreements and thereby reduce costs associated with individual billing of Medicare beneficiaries.

Thirty Day Coverage Period for Services Furnished by a Home Health Agency whose Agreement has been Terminated

Section 106 would change from the end of the calendar year to thirty days after termination of an agreement the date for ending Medicare coverage for services furnished to a beneficiary under a previously established plan by a home health agency whose Medicare agreement has been terminated. This section would bring provisions for home health agencies into conformity with provisions for hospitals and skilled nursing facilities.

Subtitle B - Changes in Reimbursement

Smaller Increase for Hospital Target Amounts

Section 111 would take into account, in determining the target amounts for fiscal year 1984 for operating costs of inpatient hospital services, only the increase in the hospital market basket index, rather than that increase plus one percent.

Fiscal Year 1984 Freeze on Payments for Physicians' Services

Section 112 would freeze the prevailing and customary charge levels for physicians' services for the 12 month period beginning with July 1983 at the levels applicable to the preceding 12 month period. The Secretary could not compensate for the one year freeze on prevailing charge levels through larger increases after the freeze ended.

Exclusive Agreements and Negotiated Rates for Certain Medical and Other Health Services

Section 113 would permit the Secretary to enter into exclusive agreements and negotiate rates for laboratory services, durable medical equipment, and certain other items and services furnished under the SMI program, but only if the Secretary determined that such an agreement would not deny access for beneficiaries to the items and services covered by such an agreement. The amounts payable under such an agreement could not exceed in the aggregate the amounts otherwise payable under the SMI program. The Secretary could waive the usual deductible and coinsurance (if the resulting payments would not exceed in the aggregate the amounts otherwise payable under the SMI program). The supplier of the items and services could not charge a beneficiary amounts other than the deductible and coinsurance (if any). This section would permit the Secretary to obtain significant savings through bulk purchases for items and services currently chosen in most cases by physicians and other health providers rather than by beneficiaries.

Subtitle C - Administrative Changes

Increased Secretarial Flexibility in Entering into Agreements for Medicare Claims Processing

Section 121 would increase the Secretary's discretion in entering into agreements for Medicare claims processing by (1) eliminating the right of providers of services to nominate intermediaries, (2) permitting the Secretary to enter into various kinds of agreements with intermediaries and carriers, not solely those based on cost, and (3) broadening the Secretary's authority to experiment with different kinds of con-

tracts by including contracts other than fixed price or performance incentive contracts and by permitting waiver of competitive bidding requirements. The section would also require new intermediaries, as well as carriers, to be health insurance organizations, and would clarify the Secretary's authority under existing law to deal directly with any provider of services or to assign any provider of services to an intermediary.

Furnishing of Items and Services to Hospital Inpatients Only By or Under Arrangements With Hospitals

Section 122 would require all items and services covered by Medicare that are furnished to hospital inpatients to be furnished by (or through) the hospital, except for physicians' services. Certain items and services (such as laboratory services) may currently be furnished to hospital inpatients by (or through) a hospital (in which case payment is made on a cost basis), or may be furnished directly by an outside supplier (in which case payment is made on a charge basis and the Medicare beneficiary is subject to deductible and coinsurance requirements). Section 132 would correct this anomaly and help reduce beneficiary out-of-pocket expenses.

Assignment of Inpatient Hospital Benefit Period, Deductible, and Coinsurance in the Order of Filing of Payment Requests

Section 123 would change the order in which hospitals are responsible for collecting from a Medicare beneficiary the inpatient hospital deductible, coinsurance, and charges for services furnished after the Medicare coverage period has expired for a particular spell of illness, in cases in which the beneficiary is an inpatient of two or more hospitals during the same spell of illness. The responsibility for collecting these amounts is currently assigned in the chronological order in which services are furnished. Section 133 would instead assign the responsibility in the order in which the hospitals submitted requests for Medicare payments, so that a hospital that provided services after another hospital, but submitted its request first, would be responsible for collecting the inpatient hospital deductible and would be credited with the first 60 days of Medicare coverage (for which no coinsurance is required). This change would simplify the administration of the Medicare program by eliminating the need to make later adjustments in amounts payable to specific hospitals.

Repeal of Special Tuberculosis Treatment Requirements

Section 124 would repeal provisions of law setting special requirements for coverage of tuberculosis treatment designed to insure that Medicare does not pay for custodial care. Due to advances in the active treatment of this disease, special safeguards against paying for custodial care for tuberculosis patients are no longer needed.

Elimination of Utilization Review Requirements

Section 125 would eliminate requirements that hospitals and skilled nursing facilities have a system in place to review the need for services furnished Medicare recipients.

Elimination of Requirement for a Railroad Retirement Board Carrier Contract

Section 126 would eliminate the requirement for a separate Railroad Retirement Board carrier contract. Under the section, SMI claims of railroad retirees would be processed by the same organizations that process other SMI claims. The section would reduce administrative costs and improve service to beneficiaries.

Medicare Recovery Against Certain Third Parties

Section 127 would clarify and enhance the ability of the Medicare program to obtain reimbursement for Medicare payments made if the Medicare beneficiary is covered by workmen's compensation, automobile or liability insurance, no-fault insurance, or an employment based group health plan (if the beneficiary is between 65 and 70 years of age or suffers from end-stage renal disease). Section 137 would make explicit the right of the United States to recover directly from the third party payer if the beneficiary did not do so himself, and to pay the beneficiary pending recovery from workmen's compensation, automobile or liability insurance, or no-fault insurance if the third party payer was not expected to pay promptly. In addition, the section would permit the United States to recover directly from the third party payer whether or not the beneficiary or anyone else brought suit (but only to the extent that the third party payer had not already made payment), would permit the United States to intervene or join in any action brought by the beneficiary or anyone else to obtain payment from the third party payer, and would subrogate the United States to any right of the individual or anyone else to payment from the third party payer. These provisions would improve the ability of the Medicare program to obtain reimbursement to which it is entitled under current law.

Providers of Services Liable for Services not Reasonable and Necessary and for Custodial Care Services

Section 128 would eliminate the right of providers of services to receive Medicare payments for services that would not have been covered by Medicare because they were not reasonable and necessary or because they were custodial care services, except for the fact that the provider of services did not know, and could not reasonably have been expected to know, that the services were not covered. The section would also

prevent a provider of services from billing a Medicare beneficiary for such services if the beneficiary were not at fault.

Indirect Payment of Supplementary Medical Insurance Benefits

Section 129 would permit payments under the SMI program to be made to a health insurer that pays full reimbursement to physicians or other persons furnishing services. Current law does not, in general, permit payments to be made to anyone other than a beneficiary or an entity providing services, so as to avoid the growth of organizations that process Medicare billings for excessive fees on behalf of physicians or others who furnish services. Payments to legitimate health insurers who pay the full bill and simply collect the reimbursable portion from Medicare can be made efficiently and do not give rise to the kinds of practices intended to be prohibited.

Elimination of Health Insurance Benefits Advisory Council

Section 130 would repeal the authority for the Health Insurance Benefits Advisory Council. This council has been moribund for years. The Secretary is able to obtain needed advice from outside experts as necessary.

Hospital Accreditation Surveys of the American Osteopathic Association Not to Be Disclosed

Section 131 would protect from disclosure hospital accreditation surveys provided to the Secretary by the American Osteopathic Association. This provision would afford such information the same protection afforded information provided by the Joint Commission on Accreditation of Hospitals (JCAH).

Elimination of Required Capital Expenditures Plan for Providers of Services

Section 132 would eliminate the requirement that hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and home health agencies include as part of a required overall plan and budget a capital expenditures plan. This requirement has unnecessarily increased the administrative burden and the costs of providers of services.

Elimination of Requirement for Accreditation of Psychiatric Hospitals by Joint Commission on Accreditation of Hospitals

Section 133 would eliminate the requirement that psychiatric hospitals be accredited by JCAH to participate in Medicare, and that a "distinct part" of such a hospital meet equivalent requirements to partipate in Medicare. Other kinds of hospitals may, but are not required to, obtain JCAH accreditation in order to obtain Medicare certification.

Elimination of Requirement that Final Cost Reports of Health Maintenance Organizations and Competitive Medical Plans be Independently Certified

Section 134 would eliminate the requirement that final cost reports of health maintenance organizations (HMOs) and competitive medical plans (CMPs) be independently certified. This requirement is an unnecessary administrative burden that is not imposed on other entities participating in Medicare.

Access to Records of Subcontractors

Section 135 would amend the provision, added by P.L. 96-499, that Medicare may not reimburse for any services furnished under an agreement between a Medicare provider and a subcontractor, the value of which is $10,000 or more over a twelve-month period, unless that agreement is pursuant to a contract containing a clause making specified provisions for access to the subcontractor's records by the Secretary and the Comptroller General. In order to alleviate the substantial paperwork burden this requirement creates for small subcontractors, who frequently provide services pursuant to informal agreements, this amendment would increase to $50,000 the minimum value subject to this requirement.

Repeal of Requirement for End-Stage Renal Disease Networks

Section 136 would repeal the requirement for ESRD networks (coordinating bodies representing ESRD facilities in a geographic area) and would make the national ESRD medical information system discretionary with the Secretary. These networks have not proved to be effective.

Flexible Sanctions for Non-Compliance with Requirements for End-Stage Renal Disease Facilities

Section 137 would permit the Secretary to apply intermediate sanctions to ESRD facilities which are out of compliance with certain program requirements, when non-compliance does not jeopardize patient health or safety or justify decertification of the facility. Permissible sanctions would include denial of reimbursement for new admissions to the facility, and graduated reduction in reimbursement.

Denial of Payment for Items and Services Ordered by a Physician Barred from Participation

Section 138 would prohibit payment for items or services (other than emergency services) furnished at the direction or on the prescription of a physician barred from participation in Medicare based on the Secretary's determination that the physician had abused the programs, or barred from participation in Medicare or Medicaid based on a conviction for a Medicare- or Medicaid-related crime.

Authority to Deny Participation to a Sanctioned Provider

Section 139 would authorize the Secretary to refuse to enter into a provider agreement with an entity if any person who has a direct or indirect ownership or control interest of 5 percent or more in the entity, or who is an officer, director, agent, or managing employee, has been sanctioned, either by denial of payment or by civil monetary penalty, for fraud or abuse related to his participation in Medicare or Medicaid.

Termination of Agreements with Institutions and Entities Where Owners or Certain Other Individuals Have Been Convicted of Certain Offenses

Section 140 would authorize the Secretary to terminate (as well as to refuse to enter into or to renew, as provided under current law) an agreement with a provider where an individual with ownership or control of the provider has been convicted of an offense related to his participation in Medicare or Medicaid.

Use of Accrediting Organizations for Certain Entities Furnishing Services

The Secretary has the authority under current law to rely on accrediting organizations in determining whether hospitals, skilled nursing facilities, home health agencies, ambulatory surgical centers, and hospice programs meet Medicare requirements. Section 141 would extend the Secretary's authority by permitting him to rely on such organizations in determining whether rural health clinics, laboratories, clinics, rehabilitation agencies, and public health agencies meet Medicare requirements (and would enact a clarifying amendment concerning his authority with respect to ambulatory surgical centers).

Elimination of Unneeded Reporting Requirements

Section 142 would eliminate the requirements that the Secretary of Health and Human Services --

-- report annually on the program for peer review of the utilization and quality of health care services,

-- include in the continuing study of Medicare a validation of the accreditation process of JCAH,

-- periodically submit legislative recommendations to further the use of home dialysis and transplantation by individuals suffering from ESRD, and

-- report annually on the Medicare ESRD program (including fifteen specifically listed items).

These requirements are costly and administratively burdensome. The Secretary has the authority to report on various matters as needed.

TITLE II - MEDICAID

Subtitle A - Changes in Payments to States

100 Percent Federal Payment for Processing of Combined Medicaid and Medicare Claims

Section 201 would provide an incentive to States to use Medicare contractors to process Medicaid claims of individuals also entitled to Medicare benefits, by increasing to 100 percent the Federal share of the administrative costs of processing these claims for services reimbursable under both Medicare and Medicaid, and by simplifying the mechanism for reimbursing Medicare contractors for the Medicaid share of payments to providers.

Extension of Reduction in Federal Share of State Medical Assistance Expenditures

Section 202 would make permanent the Medicaid provisions that limit total Federal matching payments to States. Federal payments to States would be reduced by 3 percent for fiscal year 1985 and succeeding fiscal years.

This section would also make amendments designed to simplify administration of this provision. The adjustment to the Federal matching rate for purposes of the determination would be made for expenditures in the base year, rather than expenditures in the current year. Also, claims for payment filed or processed more than two years after the expenditure would be disregarded for purposes of calculating the target amount.

Denial of Federal Financial Participation in Payments for Items and Services Ordered by a Physician Barred from Participation

Section 203 would bar Federal financial participation in payments for items or services (other than emergency services) furnished at the direction or on the prescription of a physician barred from participation in Medicare based on the Secretary's determination that the physician had abused the program or barred from participation in Medicare or Medicaid based on a conviction for a Medicare- or Medicaid-related crime.

Sanction for Provider's Failure to Furnish Information

Section 204 would permit the Secretary to deny payment to States of the Federal matching share of expenditures for medical services furnished by providers who failed to supply information requested by the Secretary concerning any claims by the provider for payment under the State plan.

Subtitle B - Changes in Eligibility, Benefits, and Cost Sharing

Amendments Concerning Third-Party Payments for Medical Expenses

Section 211 would require, rather than permit, States to require assignments of rights to third party payments for medical costs as a condition of eligibility for benefits under the State plan.

This section would also amend the provision concerning recovery of third party payments for medical expenses. Present law permits the State agency and the Federal government to retain from such recoveries only the amount equal to medical assistance payments on behalf of the individual concerned. Under the proposed amendment, the State agency would be entitled to recover its administrative costs related to the recovery from any amount remaining after reimbursing the recipient's out-of-pocket costs. Repayments to an individual for his out-of-pocket expenses would not be considered as income or resources for purposes of determining eligibility for medical assistance, for cash assistance under the Aid to Families with Dependent Children (AFDC) program or to the aged, blind, and disabled, or for food stamps under the Food Stamp Act of 1977.

Mandatory and Optional Copayments

Section 212 would require (subject to any mandatory or optional exclusions of individuals or services from copayments under the State plan, as described below) copayment by the categorically needy of $1 per day for inpatient hospital services and $1 per visit for outpatient hospital services, rural health clinic services, physician services, and clinic services; it would require copayments by the medically needy of $2 per day and $1.50 per visit for those same services. These mandatory copayment amounts could be adjusted periodically by the Secretary.

States would be prohibited from charging any copayments on services furnished to long term care inpatients, or services furnished by HMOs to categorically needy enrolled members, and permitted to exempt services to medically needy members.

States would be permitted to exempt services to pregnant women, and emergency services, from all copayment requirements; the exemption could also apply to the new mandatory copayments on inpatient and outpatient services, but there would be no Federal matching of an amount equal to the copayment the State could have charged.

States would be permitted to exempt children from all copayment requirements other than the new mandatory copayments on inpatient and outpatient services.

States could charge, for non-emergency outpatient services furnished in a hospital emergency room, up to twice the nominal amount which may be charged for other services reimbursed at the same rate as hospital emergency room services.

This section would also repeal limitations on copayments under research and demonstration waivers.

Subtitle C - Administrative Changes

Repeal of Exclusion of For-Profit Organizations from Research and Demonstration Grants

Section 221 would amend authorities for grants for research and demonstration projects for purposes related to the Social Security Act to permit grants to be made to for-profit organizations.

Amendments to Requirements for Medical Review and Independent Professional Review

Section 222 would make technical revisions to the State plan requirements for medical review (MR) and independent professional review (IPR) of nursing homes, which would clarify that there is no longer any substantive statutory distinction between MR of skilled nursing facilities (SNFs) and IPR of intermediate care facilities (ICFs).

Repeal of Special Tuberculosis Treatment Requirements

Section 223 would repeal provisions of law setting special requirements for coverage of tuberculosis treatment designed to insure that Medicaid does not pay for custodial care. Due to advances in the active treatment of this disease, special safeguards against paying for custodial care for tuberculosis patients are no longer needed.

Elimination of Utilization Review and Utilization Control Requirements

Section 224 would eliminate requirements that the State plan provide that hospitals and skilled nursing facilities must

have in effect plans to review utilization of services to ensure that institutional stays do not exceed medical necessity. This section would also eliminate the requirement that the State have in operation a program with respect to hospitals, mental hospitals, skilled nursing facilities, and intermediate care facilities of control over utilization of these services, and the penalties mandated for failure to comply with any portion of this requirement.

Requirement that States Obtain Taxpayer Identification Numbers As a Condition of Receiving Medical Assistance

Section 225 would require States to obtain taxpayer identification numbers from Medicaid applicants and recipients, in order to deter fraud, reduce errors in eligibility determination, and facilitate efficient administration.

Verification that Medical Services Have Been Furnished as Claimed

Section 226 would repeal the present requirement that Medicaid management information systems provide for written notice to be given to individuals (or to a sample of individuals) of the medical services furnished under the State plan to those individuals, and would instead require the State plan to provide an adequate method for verifying whether services for which payment is claimed under the State plan were actually furnished to covered individuals.

Authority to Waive Requirements with Respect to the Territories

Section 227 would allow the Secretary to waive or modify any Medicaid requirement for any participating territory, except requirements concerning Federal matching rates, ceilings on total Federal payments, and services for which medical assistance may be provided. This amendment would give to all territories the same flexibility given to American Samoa when it was made eligible to participate in the Medicaid program in the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248.

Termination of Agreements with Institutions and Entities Where Owners or Certain Other Individuals Have Been Convicted of Certain Offenses

Section 228 would authorize the State agency to terminate (as well as to refuse to enter into or to renew, as provided under current law) an agreement with a provider where an individual with ownership or control of the provider has been convicted of an offense related to his participation in Medicare or Medicaid.

Elimination of Requirement for Accreditation of Psychiatric Hospitals by Joint Commission on Accreditation of Hospitals

Section 229 would eliminate the requirement that psychiatric hospitals be accredited by JCAH to participate in Medicaid, and would substitute a requirement that these facilities meet appropriate standards established under Medicare.

Modification of Type of Hearing Required Before Secretary May Cancel Approval of A Skilled Nursing Facility or Intermediate Care Facility

Section 230 would repeal the requirement that a skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer meets the conditions of participation in Medicaid be afforded an opportunity for a hearing to the same extent provided in section 205(b) of the Social Security Act. This requirement would be replaced by a provision entitling the provider to an opportunity for an informal hearing before an official designated by the Secretary at which the entity would be entitled to be represented by counsel.

Flexibility in Setting Payment Rates for Hospitals Furnishing Long Term Care Services

Section 231 would eliminate the complicated special requirements for setting of payment rates for hospitals furnishing skilled nursing or intermediate care facility services under Medicaid, and would instead provide that these rates must meet the same general criteria as rates for other long term care services and hospital services.

Amendments to Authority for Home and Community-Based Care Waivers

Section 232 would amend the authority to grant to States waivers permitting home and community-based long term care services to be provided under the State plan, in order to improve the Secretary's ability to control costs under these waivers. States would be required to report quarterly to the Secretary (as well as annually, as under present law) on the cost-effectiveness of their waiver programs. The Secretary would have the option to grant initial waivers, and renewals of waivers, for periods of one, two, or three years, rather than being required to grant waivers and renewals for three-year periods.

Authority of the Secretary to Issue and Enforce Subpoenas

Section 233 would authorize the Secretary to issue and enforce subpoenas with respect to hearings, investigations, or

other proceedings or matters under the Medicaid program, to the same extent that he has that authority under the Medicare program under present law.

Interest Payments on Disputed Claims

Section 234 would redefine the disputed claims on which States are required to pay interest on the Federal matching payments if they are ultimately disallowed. The proposed amendment would make this requirement apply to amounts claimed by the State on or after October 1, 1980, rather than to expenditures for services furnished on or after that date. This amendment is needed because Federal matching payments are based on the date the State expenditure was made, irrespective of the date the service was rendered.

TITLE III - OTHER HEALTH CARE FINANCING PROVISIONS

Repeal of Authority for Payments to Promote Closing and Conversion of Underutilized Hospital Facilities

Section 301 would repeal the authority of the Secretary to make payments under Medicare to promote closing and conversion of underutilized hospital facilities (and to reimburse States under Medicaid for such payments).

Presidential Appointment of, and Executive Level IV Pay Rate for, the Administrator of the Health Care Financing Administration

Section 302 would provide that appointment to the position of Administrator of the Health Care Financing Administration be by the President by and with the advice and consent of the Senate, and would place that position in Level IV of the Executive Schedule. The position of Administrator of the Health Care Financing Administration is currently in the Senior Executive Service and appointment is by the Secretary.

Increased State Flexibility Under the Health Facility Capital Expenditures Review Program

Section 303 would increase the States' flexibility under the health facility capital expenditures review program by (1) explicitly permitting each State to determine the scope of its review program, (2) giving each State broader discretion as to the choice of the designated planning agency and the composition of its governing body or advisory board, (3) eliminating the requirement for a State appeals procedure, (4) permitting the State's designated planning agency to determine how far in advance notice of proposed capital expenditures must be

given, and (5) eliminating the authority of the Secretary to overrule on substantive grounds a decision at the State level. The section would also eliminate the national advisory council for the program.

Repeal of Requirement for Federal Funding of State Programs that Review Health Facility Capital Expenditures

Section 304 would repeal a requirement that the Secretary pay for State programs that review health facility capital expenditures.

Amendment to Requirements Concerning Reporting of Financial Interest

Section 305 would amend the definition of ownership or control interest in a provider, fiscal intermediary, or other entity participating in the Medicare or Medicaid program to provide that such an interest includes an interest in a mortgage or other obligation secured by the entity which is equal to 5 percent of the assets of the entity. This amendment would eliminate reporting requirements with respect to interests in obligations which amount to $25,000 or more, but which equal less than 5 percent of the assets of the entity.

Exclusion of Certain Entities Owned or Controlled by Individuals Convicted of Medicare- or Medicaid-Related Crimes

Section 306 would eliminate a gap in the Secretary's authority under present law to control fraud and abuse in the Medicare and Medicaid programs, by giving the Secretary authority to exclude from participation in those programs any entity in which a significant ownership or control interest is held by a person convicted of a program-related criminal offense.

Elimination of the Peer Review Program

Section 307 would eliminate the program for peer review of the utilization and quality of health care services.

A B I L L

To make improvements in the Medicare and Medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Short Title and References in Act

Section 1. (a) This Act may be cited as the "Health Care Financing Amendments of 1983".

(b) The amendments in this Act apply to the Social Security Act unless otherwise specifically stated.

TITLE I - MEDICARE

Subtitle A - Changes in Eligibility, Benefits, and Cost Sharing

Use of Medicare Physicians' Services Economic Index to Increase Annually the Supplementary Medical Insurance Deductible

Sec. 101. (a) The matter in the first sentence of section 1833(b) (42 U.S.C. 1395l(b)) preceding clause (1) is amended by striking out "of $75" and inserting instead "equal to $75 increased by the total percentage increase determined by the Secretary under the fourth sentence of section 1842(b)(3) from the 12 month period that began in July 1982 to the 12 month period that began in July of the year preceding such year and (if not a multiple of $1) rounded to the nearest multiple of $1 (or, if midway between multiples of $1, to the next higher multiple of $1)".

(b) The amendment made by subsection (a) shall apply to calendar years after 1983.

(c) The Secretary, in determining the deductible under the matter in the first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) preceding clause (1), shall disregard the provisions of section 112 of this Act.

First Full Month of Medicare Eligibility

Sec. 102. (a)(1) Subsections (a)(1), (b)(1), (c)(1)(B)(i), and (e) of section 226 (42 U.S.C. 426), section 1818(a)(1) (42 U.S.C. 1395i-2(a)(1)), section 1836(2) (42 U.S.C. 1935o(2)), section 1839(f) (42 U.S.C. 1395r(f)), subsections (d) and (g)(1) of section 1837 (42 U.S.C. 1395p), and section 1876(a)(5) (42 U.S.C. 1395mm(a)(5)) are each amended by inserting "and one month" after "age 65" each place it occurs.

(2) The matter in the first sentence of section 226(b) (42 U.S.C. 426(b)) following paragraph (2) is amended by striking out "before the month".

(3) Section 226(e)(1) (42 U.S.C. 426(e)(1)) is amended --

(A) by striking out "and" at the end of subparagraph (A),

(B) by striking out the period at the end of subparagraph (B) and inserting instead "; and", and

(C) by adding at the end the following:

"(C) paragraph (C) of section 202(e)(1) and paragraph (C) of section 202(f)(1) shall each be deemed to be amended by striking out 'and (I) has attained age 65 or (II) is not entitled to benefits under subsection (a) or section 223,';

"(D) paragraph (D) of section 202(e)(1) and paragraph (D) of section 202(f)(1) shall each be deemed to be repealed;

"(E) the matter in the first sentence of section 202(e)(1) following paragraph (F) shall be deemed to be amended --

"(i) by striking out 'becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount of such deceased individual,', and

"(ii) by inserting 'and one month' after 'age 65'; and

"(F) the matter in the first sentence of section 202(f)(1) following paragraph (F) shall be deemed to be amended --

"(i) by striking out 'or becomes entitled to an old-age insurance benefit equal to or exceeding the primary insurance amount of his deceased wife,', and

"(ii) by inserting 'and one month' after 'age 65'.".

(4) Section 226(e) (42 U.S.C. 426(e)) is amended by adding at the end the following:

"(5) For purposes of determining entitlement to hospital insurance benefits under subsection (b) in the case of an individual described in paragraph (2)(A)(i) of that subsection, 'sixty-five' in section 223(a)(1)(B) shall be deemed to read 'sixty-five and one month' and '65' in the matter in the first sentence of section 223(a)(1) following paragraph (D) shall be deemed to read '65 and one month'.

"(6) For purposes of determining entitlement to hospital insurance benefits under subsection (a) or (b) in the case of

an individual who is a qualified railroad retirement beneficiary, section 7(d)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)) shall be deemed to be amended by inserting 'and one month' after 'age 65' each place it occurs.".

(5) Section 1862(b)(3)(A)(i) (42 U.S.C. 1395y(b)(3)(A)(i)) is amended by striking out "is over 64 but" each place it occurs and inserting instead "has attained age 65 and one month but is".

(6) Section 103(a)(1) of the Social Security Amendments of 1965 (42 U.S.C. 426a(a)(1)) is amended by inserting "and one month" after "age 65".

(b) The amendments made by the preceding subsection shall apply to individuals who attain age 65 after September 1983.

Changes in Supplementary Medical Insurance Premium

Sec. 103. (a) Section 1839(g) (42 U.S.C. 1395r(g)) is amended to read as follows:

"(g) Notwithstanding the provisions of subsection (c), the monthly premium for each individual enrolled under this part for each month after June 1983 and prior to January 1984 shall be the same as the premium for June 1983.".

(b) Section 1839 (42 U.S.C. 1395r) is amended to read as follows:

"Amounts of Premiums

"Sec. 1839. (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding year. That actuarial rate shall

be the amount the Secretary estimates to be necessary so that the aggregate amount for that succeeding year with respect to those enrollees age 65 and over will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in that year. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

"(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall (except as otherwise provided in subsections (b) through (e)) be the amount determined under paragraph (3).

"(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate a monthly premium amount applicable for the succeeding year. That amount shall be equal to --

"(A) for 1984, 50 percent of the monthly actuarial rate for enrollees age 65 and over as determined under paragraph (1) for 1984,

"(B) for 1985, 55 percent of that rate as determined under paragraph (1) for 1985,

"(C) for 1986, 60 percent of that rate as determined under paragraph (1) for 1986,

"(D) for 1987, 65 percent of that rate as determined under paragraph (1) for 1987, and

"(E) for 1988 and each succeeding year, 70 percent of that rate as determined under paragraph (1) for that year.

Whenever the Secretary promulgates the dollar amount which shall be applicable for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and over as provided in paragraph (1).

"(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding year. That actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for that year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be incurred in the Federal Supplementary Medical Insurance Trust Fund for that year with respect to those enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

"(b) If the base quarter (as defined in section 215(i)(1)(A)) of any year is not a cost-of-living computation quarter (as defined in section 215(i)(1)(B)), the monthly premium of each individual enrolled under this part for the succeeding year shall (except as otherwise provided in subsection

(d)) be the same as the monthly premium (disregarding subsection (d)) of the individual for the year in which that base quarter occurred.

"(c) If subsection (b) does not apply to the monthly premiums for a year, if an individual is entitled to monthly benefits under section 202 or 223 for the month preceding the first month for which an increase under section 215(i) applies in the preceding year and for December in that preceding year, and if the monthly premium for that first month and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 223 shall (except as otherwise provided in subsection (d) or (e)) be the greater of --

"(1) the monthly premium amount determined under subsection (a)(3) for that January reduced by the amount (if any) necessary to make the monthly benefits under section 202 or 223 for that December after the deduction of the monthly premium (disregarding subsection (d)) for that January at least equal to the monthly benefits under section 202 or 223 for the month preceding that first month after the deduction of the premium (disregarding subsection (d)) for that individual for that first month, and

"(2) the monthly premium (disregarding subsection (d)) for that individual for that December.

For purposes of this subsection, retroactive adjustments or payments shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223.

"(d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to section 1837), the monthly premium determined under the preceding subsections shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which that individual may have.

"(e) If any monthly premium determined under the preceding subsections is not a multiple of 10 cents, that premium shall be rounded to the nearest multiple of 10 cents (or, if

midway between multiples of 10 cents, to the next higher multiple of 10 cents).

"(f) For purposes of subsection (d) (and section 1837(g)(1)), an individual's 'continuous period of eligibility' is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death, except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month in which he attained age 65 shall be a separate 'continuous period of eligibility' with respect to that individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).".

(c)(1) The matter in section 1818(c) (42 U.S.C. 1395i-2(c)) preceding paragraph (1) is amended by striking out "subsection (c) of section 1839" and inserting instead "subsection (d) of section 1839".

(2) Section 1837(g)(1) (42 U.S.C. 1395p(g)(1)) is amended by striking out "1839(e)" and inserting instead "1839(f)".

(3) Section 1843(d)(1) (42 U.S.C. 1395v(d)(1)) is amended by striking out "subsection (c)" and inserting instead "subsection (d)".

(4) Section 1844(a)(1)(A)(i) (42 U.S.C. 1395w(a)(1)(A)(i)) is amended --

(A) by striking out "1839(c)(1)" and inserting instead "1839(a)(1)", and

(B) by striking out "1839(c)(3) or 1839(g)" and inserting instead "1839(a)(3) or 1839(b)".

(5) Section 1844(a)(1)(B)(i) (42 U.S.C. 1395w(a)(1)(B)(i)) is amended --

(A) by striking out "1839(c)(4)" and inserting instead "1839(a)(4)", and

(B) by striking out "1839(c)(3) or 1839(g)" and inserting instead "1839(a)(3) or 1839(b)".

(6) Section 1876(a)(5) (42 U.S.C. 1395mm(a)(5)) is amended --

(A) in subparagraph (A)(ii), by striking out "1839(c)(1)" and inserting instead "1839(a)(1)", and

(B) in subparagraph (B)(ii), by striking out "1839(c)(4)" and inserting instead "1839(a)(4)".

(d) The amendments made by subsections (b) and (c) apply to premiums (and other payments) for months after December 1983.

Cost Sharing for Durable Medical Equipment Furnished as a Home Health Benefit

Sec. 104. (a)(1) The matter in section 1814(b) (42 U.S.C. 1395f(b)) preceding paragraph (1) is amended by inserting "and other than a home health agency with respect to durable medical equipment" after "hospice care".

(2) Section 1814 (42 U.S.C. 1395f) is amended by adding at the end the following:

"Payments to Home Health Agencies for Durable Medical Equipment

"(j) The amount paid to any home health agency with respect to durable medical equipment for which payment may be made under this part shall be --

"(1) the lesser of --

"(A) the reasonable cost of such equipment, as determined under section 1861(v), and

"(B) the customary charges with respect to such equipment,

less the amount the home health agency may charge as described in section 1866(a)(2)(A)(ii), but in no case may the payment for such equipment exceed 80 percent of such reasonable cost, or

"(2) if such equipment is furnished by a public home health agency free of charge or at nominal charge to the public, the amount which the Secretary finds will provide fair compensation to the home health agency.".

(b)(1) The matter in section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) preceding clause (i) is amended by inserting "(other than durable medical equipment)" after "home health services".

(2) The matter in section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) preceding clause (i) is amended by inserting "items and" after "other".

(c) Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting "or which are durable medical equipment furnished as home health services" after "part B".

(d)(1) The first sentence of section 1833(f)(1) (42 U.S.C. 1395*l*(f)(1)) is amended by striking out "as described in section 1861(s)(6)".

(2) Section 1833(f)(2) (42 U.S.C. 1395*l*(f)(2)) is amended --

(A) by striking out "the 20 percent" and inserting instead "any", and

(B) by striking out "under subsection (a)".

(3) Section 1833(f)(3) (42 U.S.C. 1395*l*(f)(3)) is amended by striking out "paragraph (1)" and inserting instead "subsection (a)".

(4)(A) Subsection (f) of section 1833 (42 U.S.C. 1395*l*) is redesignated as section 1888, is assigned the heading "Purchase of Durable Medical Equipment", and is moved to the end of part C.

(B) Paragraphs (1) through (4) of section 1888 are redesignated as subsections (a) through (d).

(e)(1) Section 1861(m)(5) (42 U.S.C. 1395x(m)(5)) is amended by striking out ", and the use of medical appliances" and inserting instead "and durable medical equipment".

(2) Section 1861(s)(6) (42 U.S.C. 1395x(s)(6)) is amended by striking out everything after "durable medical equipment" but before the semicolon.

(3) Section 1861 (42 U.S.C. 1395x) is amended by adding after subsection (m) the following:

"Durable Medical Equipment

"(n) The term 'durable medical equipment' includes iron

lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased.".

(4) Section 1861(cc)(1)(G) (42 U.S.C. 1395x(cc)(1)(G)) is amended by striking out ", appliances, and equipment, including the purchase or rental of equipment" and inserting instead "and durable medical equipment".

(f) Section 1886(d)(2) (42 U.S.C. 1395ww(d)(2)) is amended --

(1) by redesignating subparagraphs (B) and (C) as (C) and (D), respectively, and

(2) by inserting the following after subparagraph (A):

"(B) Section 1814(j)(1)(B).".

(g) The amendments made by the preceding subsections apply to items and services furnished after September 1983.

Elimination of Deductible for Diagnostic Tests Performed in a Laboratory Which has Entered into A Negotiated Rate Agreement with the Secretary

Sec. 105. (a) The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended --

(1) by striking out "and" at the end of clause (2), and

(2) by inserting ", and (4) such deductible shall not apply to diagnostic tests performed in a laboratory for which the Secretary has established a payment rate under subsection (h)" before the period.

(b) The second sentence of section 1833(h) (42 U.S.C. 1395l(h)) is amended by inserting ", and any deductibles under section 1833(b) with respect to," after "made for".

(c) The amendments made by the preceding subsections apply to diagnostic tests furnished after September 1983.

Thirty Day Coverage Period for Services Furnished by a Home Health Agency Whose Agreement Has Been Terminated

Sec. 106. (a) Section 1866(b)(4)(B) (42 U.S.C. 1395cc(b)(4)(B)) is amended by striking out "the calendar year in which" and inserting instead "thirty days after".

(b) The amendment made by subsection (a) applies with respect to terminations whose effective date falls after 60 days after the date of enactment of this Act.

Subtitle B - Changes in Reimbursement

Smaller Increase for Hospital Target Amounts

Sec. 111. Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended --

(1) by striking out "1 percentage point plus" and inserting instead "(i)", and

(2) by inserting ", plus (ii) in the case of cost reporting periods beginning before October 1, 1983 or

after September 30, 1984, 1 percentage point" before the period.

Fiscal Year 1984 Freeze on Payments for Physicians' Services

Sec. 112. (a) In determining reasonable charges under part B of title XVIII of the Social Security Act for physicians' services, the prevailing and customary charge levels that apply to services furnished after June 1982 but before July 1983 shall also apply to services furnished after June 1983 but before July 1984.

(b) The Secretary, in determining prevailing charge levels under the fourth sentence of section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) for physicians' services furnished after June 1984, shall treat the prevailing charge levels applied under subsection (a) to the 12 month period beginning with July 1983 as having fully provided for economic changes which would have been taken into account were it not for that subsection.

Exclusive Agreements and Negotiated Rates for Certain Medical and Other Health Services

Sec. 113. (a) Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

"(k)(1) The Secretary may enter into an agreement with a public or private entity under which --

"(A) the entity shall furnish one or more types of items or services specified in paragraph (3), (5), (6), (7), (8), (9) or (10) of section 1861(s) to individuals in specified geographic areas who are entitled to benefits under this part, and

"(B) the entity shall accept amounts specified in the agreement (including any deductible or coinsurance imposed under this section) as full payment for the items or services, not to exceed the amounts that the Secretary estimates in the aggregate would otherwise be paid under this part (including any such deductible or coinsurance) for those items and services.

"(2) The Secretary may, for items and services furnished under such an agreement, waive any coinsurance or deductible otherwise imposed under this section if he estimates that the amounts to be paid in the aggregate will not exceed the amounts that would otherwise be paid under this part for those items and services.

"(3) The Secretary may limit the right of any individual to payment under this part for items or services furnished other than under such an agreement if those items or services may be furnished under such an agreement, but only if the Secretary determines that such an agreement will not deny access for individuals entitled to benefits under this part to those items and services.

"(4) The Secretary may enter into agreements under this subsection without regard to section 3709 of the Revised Statutes (41 U.S.C. 5) or any provision of law requiring competition.".

(b) Section 1833(a)(1) (42 U.S.C. 1395*l*(a)(1)) is amended --

(1) by striking out "and" at the end of clause (F), and

(2) by adding at the end the following: "and (H) with respect to items or services furnished under an agreement entered into under subsection (k), the amounts paid shall be 80 percent of the amounts specified in that agreement (or 100 percent, if the Secretary waives coinsurance under subsection (k)(2));".

(c) The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) (as amended by section 105(a) of this Act) is further amended --

(1) by striking out "and" at the end of clause (3), and

(2) by inserting ", and (5) such deductible shall not apply to items and services for which the Secretary has granted a waiver under subsection (k)(2)" before the period.

(d) Section 1802 (42 U.S.C. 1395a) is amended by inserting ", except as otherwise provided under section 1833(k)(3)" before the period.

Subtitle C - Administrative Changes

Increased Secretarial Flexibility in Entering Into Agreements for Medicare Claims Processing

Sec. 121. (a) Section 1816 (42 U.S.C. 1395h) is amended to read as follows:

"Use of Intermediaries to Facilitate
Payment to Providers of Services

"Sec. 1816. (a) The Secretary is authorized to enter into agreements with intermediaries providing for their determination (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the agreements) of the amount of the payments required pursuant to this part to be made to providers of services assigned by the Secretary to specific intermediaries, and for the making of such payments by intermediaries to those providers of services. Such agreements may also include provision for intermediaries to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as providers of services, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary, (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part, and (C) to perform such other functions as are necessary to carry out this subsection. The Secretary may either directly determine the amount of payments to be made and make payments to any provider of services, or assign any provider of

services (including a provider of services with which the Secretary has previously dealt directly) to any intermediary.

"(b) The Secretary shall not enter into or renew an agreement with any intermediary under this section unless --

"(1) he finds --

"(A) after applying the standards, criteria, and procedures developed under subsection (d), that to do so is consistent with the effective and efficient administration of this part, and

"(B) that such intermediary is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance, and

"(2) such intermediary agrees --

"(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

"(B) to provide the Secretary with access to all such data, information, and claims processing operations, as the Secretary may find necessary in performing his functions under this part.

"(c) An agreement with any intermediary under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of

funds to the intermediary for the making of payments by it under subsection (a). An agreement with an intermediary under this section may be entered into without regard to section 3709 of the Revised Statutes or any provision of law requiring competition.

"(d) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an intermediary, whether the Secretary should assign or reassign a provider of services to an intermediary, and whether the Secretary should designate an intermediary to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate the intermediary's (1) overall performance of claims processing and other related functions required to be performed by an intermediary under an agreement entered into under this section, and (2) performance of such functions with respect to specific providers of services; and the Secretary shall establish, by regulation, standards and criteria with respect to the efficient and effective administration of this part.

"(e) An agreement with the Secretary under this section may be terminated --

"(1) by the intermediary which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers to which it provides services as may be specified in regulations, or

"(2) by the Secretary at such time and upon such notice to the intermediary, to the providers to which the

intermediary provides services, and to the public, as may be specified in regulations.

"(f) An agreement with an intermediary under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(g)(1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

"(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) No intermediary shall be liable to the United States for any payments referred to in paragraph (1) or (2).

"(h) For purpose of this section, the term 'intermediary' means (1) a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of

premiums or other periodic charges payable to the intermediary, including a health benefits plan duly sponsored or underwritten by an employee organization, or (2) an agency or organization with which an agreement was in effect under this section on the date of enactment of the Health Care Financing Amendments of 1982.".

(b)(1) Section 1842(c) (42 U.S.C. 1395u(c)) is amended by striking out ", and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract".

(2) Section 1842(f) (42 U.S.C. 1395u(f)) is amended to read as follows:

"(f) For purpose of this part, the term 'carrier' means a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization.".

(c)(1) Section 402(a)(1)(F) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)(1)(F)) is amended by striking out "or performance incentive contract" and inserting

instead ", performance incentive, or other kinds of contracts".

(2) Section 402(a) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)) is amended by adding at the end the following:

"(3) Contracts may be entered into under paragraph (1)(F) without regard to section 3709 of the Revised Statutes or any provision of law requiring competition.".

(d) The amendments made by the preceding subsections are effective October 1, 1983.

Furnishing of Items and Services to Hospital Inpatients Only By or Under Arrangements With Hospitals

Sec. 122. (a) Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended --

(1) by striking out "and" at the end of subparagraph (D),

(2) by striking out the period at the end of subparagraph (E) and adding instead ", and", and

(3) by adding at the end the following:

"(F) if the provider of services is a hospital, to have all items and services (other than physicians' services) (1) that are furnished to an individual who is an inpatient of the hospital and (2) for which the individual is entitled to have payment made under this title, furnished by the hospital, or by others under arrangements with them made by the hospital.".

(b) Section 1862(a) (42 U.S.C. 1395y(a)) is amended --

(1) by striking out "or" at the end of paragraph (12),

(2) by striking out the period at the end of paragraph (13) and inserting instead "; or", and

(3) by adding at the end the following:

"(14) which are other than physicians' services and are furnished to an individual who is an inpatient of a hospital by entities other than the hospital or others under arrangements with them made by the hospital.".

(b) The amendments made by subsection (a) apply to items and services furnished after September 1983.

Assignment of Inpatient Hospital Benefit Period, Deductible, and Coinsurance in the Order of Filing of Payment Requests

Sec. 123. (a) Section 1812(b)(1) (42 U.S.C. 1395d(b)(1)) is amended --

(1) by inserting "as an inpatient of a particular hospital" after "inpatient hospital services furnished to him", and

(2) by inserting "as an inpatient of that hospital, or of another hospital that has previously filed a request for payment under this part for such services," after "150 days during such spell".

(b)(1) The first sentence of section 1813(a)(1) (42 U.S.C. 1395e(a)(1)) is amended by inserting "as an inpatient of a hospital that first files a request for payment under this part for such services" after "any spell of illness".

(2) The second sentence of section 1813(a)(1) (42 U.S.C. 1395e(a)(1)) is amended to read as follows: "In addition, the amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to --

"(A) one-fourth of the inpatient hospital deductible for each day (after the 60th but before the 91st day) on which such individual is furnished such services during such spell of illness as an inpatient of a particular hospital, or of another hospital that has previously filed a request for payment under this part for such services; and

"(B) one-half of the inpatient hospital deductible for each day (after the 90th but before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness as an inpatient of a particular hospital, or of another hospital that has previously filed a request for payment under this part for such services;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).".

(3) Section 1813(a)(2) (42 U.S.C. 1395e(a)(2)) is amended --

(A) by striking out "to any provider of services", and

(B) by inserting "as an inpatient of a particular hospital, or of another hospital that has previously filed a request for payment under this title for such services" after "furnished to him".

(c) The amendments made by the preceding subsections apply to spells of illness beginning after September 1983.

Repeal of Special Tuberculosis Treatment Requirements

Sec. 124. (a) Section 1814(a) (42 U.S.C. 1395f(a)) is amended --

(1) by striking out paragraphs (2)(B) and (5), and

(2) in the penultimate sentence, by striking out "(B),".

(b)(1) Subsections (d) and (g) of section 1861 (42 U.S.C. 1395x) are repealed.

(2) The fifth sentence of section 1861(e) (42 U.S.C. 1395x(e)) is amended by striking out "or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or".

(3) The matter in the first sentence of section 1861(j) (42 U.S.C. 1395x(j)) following paragraph (15) is amended by striking out "or tuberculosis".

(4) Section 1866(b)(3) (42 U.S.C. 1395cc(b)(3)) is amended by striking out "tuberculosis hospital services and".

(5) The first sentence of section 1866(d) (42 U.S.C. 1395cc(d)) is amended by striking out "inpatient tuberculosis hospital services and".

Elimination of Utilization Review Requirements

Sec. 125. (a) Sections 1814(a)(6), 1814(a)(7), 1815(b), 1861(e)(6), 1861(j)(8), 1861(k), 1861(w)(2), and 1866(d) (42 U.S.C. 1395f(a)(6), 1395f(a)(7), 1395g(b), 1395x(e)(6), 1395x(j)(8), 1395x(k), 1395x(w)(2), & 1395cc(d)) are repealed.

(b)(1) Section 1814(a)(as amended by section 124(a) of this Act) (42 U.S.C. 1395f(a)) is further amended --

(A) in paragraph (2)(C), by striking out "paragraphs (6) and (9)" and inserting instead "paragraph (9)",

(B) by adding "and" at the end of paragraph (4), and

(C) by renumbering paragraph (8) as (5).

(2) Section 1842(a)(2) (42 U.S.C. 1395u(a)(2)) is amended --

(A) by striking out subparagraph (A),

(B) by striking out the subparagraph designation "(B)",

(C) by inserting "and" after "improvement,", and

(D) by striking out ", and provide procedures for" and all that follows up to the semicolon.

(3) Section 1861(r)(3) (42 U.S.C. 1395x(r)(3)) is amended by striking out "subsections (k) and (m)" each place it occurs and inserting instead "subsection (m)".

(4) Section 1861(w) (42 U.S.C. 1395x(w)) is amended by striking out the paragraph designation "(1)".

(5)(A) The first sentence of section 1865(a) (42 U.S.C. 1395bb(a)) is amended --

(i) by striking out paragraph (3), and

(ii) by renumbering paragraph (4) as (3).

(B) The second sentence of section 1865(a) (42 U.S.C. 1395bb(a)) is amended to read as follows: "If such Commission, as a condition for accreditation of a hospital, imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (3) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with the standard described in such paragraph (3).".

Elimination of Requirement for a Railroad Retirement Board Carrier Contract

Sec. 126. (a) Section 1842(g) (42 U.S.C. 1395u(g)) is repealed.

(b) The first sentence of section 1841(i) (42 U.S.C. 1395t(i)) is amended by striking out "and section 1842(g)".

(c) The amendments made by the preceding subsections are effective one year after the date of enactment of this Act, or at such earlier time as the Secretary and the Railroad Retirement Board may agree.

Medicare Recovery Against Certain Third Parties

Sec. 127. (a) Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended --

(1) in the first sentence, by inserting "promptly" after "to be made",

(2) in the second sentence, by inserting "or may be" after "has been", and

(3) by inserting after the second sentence the following: "The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a law, policy, plan, or insurance (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment), by bringing an action against the individual or other entity to which payment has been so made, or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a law, policy, plan, or insurance.".

(b) Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended --

(1) in the first sentence, by inserting "or may be" after "has been", and

(2) by inserting after the first sentence the following: "The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a

plan (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment), by bringing an action against the individual or other entity to which payment has been so made, or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right of the individual or any other entity to payment under such a plan.".

(c) Section 1862(b)(3)(A)(ii) (42 U.S.C. 1395y(b)(3)(A)(ii)) is amended --

(1) in the first sentence, by inserting "or may be" after "has been", and

(2) by inserting after the first sentence the following: "The United States may recover the amount of any such payment under this title by bringing an action against the entity responsible for payment under such a plan (if the entity would be required to make payment if an appropriate claim were pursued, but only to the extent that the entity has not already made payment), by bringing an action against the individual or other entity to which payment has been so made, or by joining or intervening in any action related to the events that gave rise to the need for the item or service, and shall be subrogated (to the extent of the payment under this title) to any right

of the individual or any other entity to payment under such a plan.".

Providers of Services Liable for Services not Reasonable and Necessary and for Custodial Care Services

Sec. 128. (a)(1) The first sentence of section 1879(a) (42 U.S.C. 1395pp(a)) is amended --

(A) by striking out "or (9)", "and section 1862(a)(9)", and "part A or" each place they occur,

(B) by striking out "provider of services or by another" and inserting instead "physician or other", and

(C) by striking out "provider of services or such" and inserting instead "physician or".

(2) The second sentence of section 1879(a) (42 U.S.C. 1395pp(a)) is amended --

(A) by striking out "provider of services or such" and inserting instead "physician or", and

(B) by striking out "provider or such" and inserting instead "physician or".

(3) The third sentence of section 1879(a) (42 U.S.C. 1395pp(a)) is amended --

(A) by striking out "or (9)", and

(B) by striking out "provider" each place it occurs and inserting instead "physician".

(4) The first sentence of section 1879(b) (42 U.S.C. 1395pp(b)) is amended to read as follows: "Where --

"(1) a determination is made that, by reason of section 1862(a)(1) or (9), payment may not be made under

part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services, or by an another person pursuant to an agreement under section 1842(b)(3)(B)(ii), and

"(2)(A) such individual did not know, and could not reasonably have been expected to know, and (B) such person (if not a provider of services) knew, or could reasonably have been expected to know, that payment would not be made for such items or services under such part A or B,

then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual, subject to the deductible and coinsurance provisions of this title, for any payments received from such individual by such provider or such other person, as the case may be, for such items or services.".

(5) Section 1879(c) (42 U.S.C. 1395pp(c)) is amended by striking out "subsection (a)" and inserting instead "subsection (b)".

(b) Section 1866(a)(1)(B) (42 U.S.C. 1395cc(a)(1)(B)) is amended --

(1) by striking out the clause designation "(i)", and

(2) by striking out "and (ii)" and all that follows up to the comma.

(c) Section 1154(a)(2)(B) (42 U.S.C. 1320c-3(a)(2)(B)) is amended by striking out everything after "two days" up to the semicolon.

(d) The amendments made by the preceding subsections apply to items and services furnished after September 1983.

Indirect Payment of Supplementary Medical Insurance Benefits

Sec. 129. (a) The first sentence of section 1842(b)(5) (42 U.S.C. 1395u(b)(5)) is amended --

(1) by inserting "(i)" after "(A)",

(2) by striking out "(B)" and inserting instead "(ii)", and

(3) by inserting ", or (B) to an entity (i) which provides coverage of the service under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part" before the period.

(b) The second sentence of section 1842(b)(5) (42 U.S.C. 1395u(b)(5)) is amended by striking out "or (B)".

Elimination of Health Insurance Benefits Advisory Council

Sec. 130. (a) Section 1867 (42 U.S.C. 1395dd) is repealed.

(b)(1) The first sentence of section 1863 (42 U.S.C. 1395z) is amended by striking out "the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies," and inserting instead "appropriate State agencies".

(2) The first sentence of section 7(d)(4) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(4)) is amended by striking out "1867,".

(3) Section 361(i) of the Social Security Amendments of 1967 (42 U.S.C. 907a(i)) is repealed.

Hospital Accreditation Surveys of the American Osteopathic Association Not to Be Disclosed

Sec. 131. Section 1865(a) (42 U.S.C. 1395bb(a)) is amended --

(1) in paragraph (2), by striking out "(on a confidential basis)", and

(2) by adding at the end the following: "The Secretary may not disclose any accreditation survey made and released to him by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association of an institution accredited by either of those bodies as a hospital.".

Elimination of Required Capital Expenditures Plan for Providers of Services

Sec. 132. Section 1861(z) (42 U.S.C. 1395x(z)) is amended by striking out paragraph (2).

Elimination of Requirement for Accreditation of Psychiatric Hospitals by Joint Commission on Accreditation of Hospitals

Sec. 133. (a) The first sentence of section 1861(f) (42 U.S.C. 1395x(f)) is amended --

(1) by adding "and" at the end of paragraph (3),

(2) by striking out the semicolon and "and" at the end of paragraph (4) and substituting a period, and

(3) by striking out paragraph (5).

(b) The second sentence of section 1861(f) (42 U.S.C. 1395x(f)) is amended by striking out "if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary".

Elimination of Requirement that Final Cost Reports of Health Maintenance Organizations and Competitive Medical Plans be Independently Certified

Sec. 134. Section 1876(h)(4)(A) (42 U.S.C. 1395mm(h)(4)(A)) is amended by striking out "in an independently certified financial statement".

Access to Records of Subcontractors

Sec. 135. Section 1861(v)(1)(I) (42 U.S.C. 1395x(v)(1)(I)) is amended by striking out "$10,000" each place it occurs and inserting instead "$50,000".

Repeal of Requirement for End-Stage Renal Disease Networks

Sec. 136. (a)(1) Section 1881(c)(1) (42 U.S.C. 1395rr(c)(1)) is amended to read as follows:

"(c)(1) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary may establish a national end-stage renal disease medical information system.".

(2) Paragraphs (2), (4), and (5) of section 1881(c) (42 U.S.C. 1395rr(c)) are repealed.

(3) Section 1881(c)(3) (42 U.S.C. 1395rr(c)(3)) is amended --

(A) by striking out "the data contained in the network's annual report and such other" and inserting instead "such",

(B) by striking out "network plans" and inserting instead "the Secretary's plans", and

(C) by striking out "network's plans" and inserting instead "those plans".

(4) Paragraph (6) of section 1881(c) (42 U.S.C. 1395rr(c)) is renumbered as paragraph (2), is inserted after paragraph (1), and is amended in the second sentence by striking out "and network".

(b) Section 1881(g) (42 U.S.C. 1395rr(g)) is amended --

(1) in paragraph (1), by striking out ", nationally and by renal disease network,",

(2) by adding "and" at the end of paragraph (13),

(3) by striking out paragraph (14), and

(4) by renumbering paragraph (15) as (14).

(c) The amendments made by the preceding subsections are effective October 1, 1983.

Flexible Sanctions for Non-Compliance with Requirements for End-Stage Renal Disease Facilities

Sec. 137. Section 1881(c)(3) (as amended by section 136(a)(3) of this Act) (42 U.S.C. 1395rr(c)(3)) is further amended by adding at the end the following: "Where the Secretary in addition determines that the facility's or provider's failure to cooperate with the Secretary's plans and goals does not jeopardize patient health or safety or justify

termination of certification, he may instead, after reasonable notice to the provider or facility and to the public, impose such other sanctions as appropriate, which sanctions may include denial of reimbursement with respect to some or all patients admitted to the facility after the date of the notice, and graduated reduction in reimbursement for all patients.".

Denial of Payment for Items and Services Ordered by a Physician Barred from Participation

Sec. 138. (a) Section 1862(e) (42 U.S.C. 1395y(e)) is amended --

(1) by inserting "(1)" after "(e)", and

(2) by adding at the end the following new paragraph:

"(2) No payment may be made under this title with respect to any item or service (other than an emergency item or service) furnished at the direction or on the prescription of a physician during the period when he is barred pursuant to subsection (d) or section 1128 from participation in the program under this title or title XIX.".

(b) The amendment made by subsection (a) shall apply to items and services furnished after September 1983.

Authority to Deny Participation to a Sanctioned Provider

Sec. 139. Section 1866(a)(3) (42 U.S.C. 1395cc(a)(3)) is amended by striking out "is a person described in section 1126(a)." and inserting instead the following:

"is a person --

"(A) described in section 1126(a), or

"(B) against whom there has been assessed a civil money penalty under section 1128A, or

"(C) to whom payment has been denied pursuant to section 1862(d).".

Termination of Agreements with Institutions and Entities Where Owners or Certain Other Individuals Have Been Convicted of Certain Offenses

Sec. 140. Section 1866(b)(2)(G) (42 U.S.C. 1395cc(b)(2)(G)) is amended by inserting before the period ", or that any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a)".

Use of Accrediting Organizations for Certain Entities Furnishing Services

Sec. 141 . The third sentence of section 1865(a) (42 U.S.C. 1395bb(a)) is amended --

(1) by striking out "section 1861(e), (j), (o), or (dd)" and inserting instead "section 1832(a)(2)(E)(i), 1861(e), 1861(j), 1861(o), 1861(p)(4)(A), or 1861(p)(4)(B), paragraphs (11) and (12) of section 1861(s), or section 1861(aa)(2) or 1861(dd)",

(2) by striking out "an institution or agency" and inserting instead "a center, institution, agency, clinic, laboratory, or organization", and

(3) by striking out "such institution or agency" and inserting instead "that center, institution, agency, clinic, laboratory, or organization".

Elimination of Unneeded Reporting Requirements

Sec. 142. (a) Section 1161 (42 U.S.C. 1320c-10) is repealed.

(b) Section 1875(b) (42 U.S.C. 1395ll(b)) is amended by striking out "a validation of the accreditation process of the Joint Commission on the Accreditation of Hospitals,".

(c) Section 1881(c)(6) (42 U.S.C. 1395rr(c)(6)) is amended by striking out the last sentence.

(d) Section 1881(g) (42 U.S.C. 1395rr(g)) is repealed.

TITLE II - MEDICAID

Subtitle A - Changes in Payments to States

100 Percent Federal Payment for Processing of Combined Medicaid and Medicare Claims

Sec. 201. Section 1903 (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

"(v)(1) From the sums appropriated therefor, in addition to sums paid to States under the provisions of subsection (a), the Secretary shall, for each State which has a plan approved under this title, for each quarter, pay directly to fiscal intermediaries and carriers processing claims under title XVIII --

"(A) 100 per centum of that portion of the total administrative costs of processing claims for items and services furnished to individuals entitled, with respect to those items and services, both to medical assistance under the State plan and to reimbursement under title XVIII (subject to any applicable coinsurance or deductible) which exceeds the costs which would be

incurred in processing only claims for benefits under title XVIII, plus

"(B) 100 per centum of the amounts paid on such claims by fiscal intermediaries and carriers as medical assistance under this title.

"(2) The Secretary shall reduce the payment to a State under subsections (a)(1) and (a)(5) by an amount equal to the non-Federal share of payments under claims processed as provided in paragraph (1).

"(3) Payments and adjustments in accordance with this subsection shall be made for each quarter, and may be made in advance or by way of reimbursement."

Extension of Reduction in Federal Share of Total State Medical Assistance Expenditures

Sec. 202. (a) Section 1903(s)(1)(A) (42 U.S.C. 1396b(s)(1)(A)) is amended --

(1) by striking out "and" at the end of clause (ii),

(2) by inserting "and" at the end of clause (iii), and

(3) by adding after clause (iii) the following new clause:

"(iv) fiscal year 1985 and each succeeding fiscal year, shall be reduced by 3 percent,".

(b) Section 1903(t)(1) (42 U.S.C. 1396b(t)(1)) is amended, in the matter preceding subparagraph (A), by striking out "each of fiscal years 1982, 1983, and 1984" and inserting instead "fiscal year 1982 and each succeeding fiscal year".

(c) Section 1903(t)(1)(C) (42 U.S.C. 1396b(t)(1)(C)) is amended--

(1) by inserting after "1984", the first time it occurs, "and each succeeding fiscal year", and

(2) by striking out "the 24-month period ending on September 30, 1984" and inserting instead "the period beginning on October 1, 1982 and ending on September 30 of that fiscal year".

(d) Section 1903(t)(2) (42 U.S.C. 1396b(t)(2)) is amended, in the matter preceding paragraph (A), by striking out "and ending with fiscal year 1985".

(e) Section 1903(t)(3) (42 U.S.C. 1396b(t)(3)) is amended by inserting "(A)" after "(3)" and adding at he end the following new paragraph:

"(B) Only for the purpose of computing under this subsection the Federal share of expenditures for a State for fiscal year 1985 (and succeeding fiscal years), in the case of the payment which may be made for the first quarter of fiscal year 1986 and of each succeeding fiscal year, the Federal medical assistance percentage for fiscal year 1985 (or the appropriate succeeding fiscal year) shall be substituted for the Federal medical assistance percentage for fiscal year 1981 in calculating the target amount under paragraph (1)(A).".

(f) Section 1903(t) (42 U.S.C. 1396b(t)) is amended by adding at the end the following new paragraph:

"(4) Notwithstanding any other provision of this section, any claims for payment relating to expenditures under this

title filed by the State or processed by the Secretary after the end of the two-year period described in section 1132(a) shall be disregarded for purposes of this subsection.".

Denial of Federal Financial Participation in Payments for Items and Services Ordered by a Physician Barred from Participation

Sec. 203. (a) Section 1903(i) (42 U.S.C. 1395b(i)) is amended --

(1) in paragraph (6), by striking out the period at the end and inserting instead "; or", and

(2) by adding at the end the following new paragraph:

"(7) with respect to any amount expended for an item or service (other than an emergency item or service) furnished at the direction or on the prescription of a physician, if payment may not be made under this title or title XVIII with respect to services furnished by such physician by reason of a determination by the Secretary under section 1862(d)(1) or 1128.".

(b) The amendment made by subsection (a) shall apply to items and services furnished after September 1983.

Sanction for Provider's Failure to Furnish Information

Sec. 204. Section 1903 (as amended by section 202 of this Act) (42 U.S.C. 1396b) is further amended by adding at the end the following new subsection:

"(w) Notwithstanding any other provision of this section, the Secretary may reduce the amount which would otherwise be considered as expenditures under the State plan by an amount

equal to payments made by the State to any person or institution that has failed to furnish to the Secretary, upon request, informattion regarding any payments claimed by such person or institution for providing services under the plan.".

Subtitle B - Changes in Eligibility, Benefits, and Cost Sharing

Amendments Concerning Third-Party Payments for Medical Expenses

Sec. 211. (a)(1) Section 1912(a) (42 U.S.C. 1396k(a)) is amended in the matter preceding paragraph (1) by striking out "may" and inserting instead "shall".

(2) Section 1902(a) (42 U.S.C. 1396a(a)) is amended --

(A) by striking out "and" at the end of paragraph (43),

(B) by striking the period at the end of paragraph (44) and inserting instead "; and", and

(C) by adding after paragraph (44) the following new paragraph:

"(45) provide for assignment of rights of payment as a condition of eligibility under the plan in accordance with section 1912(a)(1).".

(b) Section 1912(b) (42 U.S.C. 1396k(b)) is amended to read as follows:

"(b) Any amount collected by the State under an assignment made under the provisions of this section shall be distributed as follows:

"(1) the State shall retain such part as may be necessary to reimburse it for medical assistance payments

made on behalf of the individual with respect to whom such assignment was executed (with appropriate reimbursement of the Secretary to the extent of Federal financial participation in the financing of such medical assistance) for items and services for which the third-party payment was made,

"(2) the State agency shall retain any portion of a third-party payment which reimburses expenditures for medical care which were deducted from income and resources to establish eligibility for medical assistance,

"(3) the State agency shall pay to the individual such part of any remainder as may be necessary to pay costs or debts incurred by such individual for care and services with respect to which the third-party payment was made (but, notwithstanding any other provision of law, such payments shall not be considered income or resources for purposes of eligibility for benefits under any State program under this title or titles I, IV, X, XIV, or XVI of this Act, under the Federal program under title XVI of this Act, or under the Food Stamp Act of 1977),

"(4) the State agency shall retain (with appropriate reimbursement to the Secretary of the Federal share of such expenses) such part of any remainder as may be necessary to reimburse it for administrative expenses of obtaining recovery, not to exceed an amount determined either by dividing the total administrative costs of pursuing such recoveries by the number of claims pursued,

or by another method approved by the Secretary which attributes to each claim pursued a reasonable share of the total administrative cost of such activities, and

"(5) the State agency shall pay any remainder to the individual.".

(c)(1) The amendments made by subsection (a) shall become effective October 1, 1983, except that, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order to meet the additional requirements imposed by this section, the State plan shall not be regarded as failing to comply with the requirements of that title, and Federal payments under section 1903 of that Act (42 U.S.C. 1396b) shall not be reduced with respect to expenditures by the State for medical assistance for individuals failing to comply with these additional requirements, before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

(2) The amendment made by subsection (b) shall apply with respect to amounts recovered by the State after September 1983.

Mandatory and Optional Copayments

Sec. 212. (a)(1) Section 1916(a)(2) (42 U.S.C. 1396o(a)(2)) is amended --

(A) by striking out subparagraphs (A) and (B), and redesignating subparagraphs (C) and (D) as subparagraphs (A) and (B), and

(B) by revising subparagraph (B), as redesignated, to read as follows:

"(B) services furnished to an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled;".

(2) Section 1916(a) (42 U.S.C. 1396o(a)) is further amended by redesignating paragraph (3) as paragraph (5) and inserting after paragraph (2) the following new paragraphs:

"(3) at the option of the State, no deduction, cost sharing or similar charge will be imposed under the plan with respect to --

"(A) services (other than services described in paragraph (4)) furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

"(B) services (including, at the option of the State, services described in paragraph (4)) furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women), or

"(C) emergency services, as defined by the State) (including, at the option of the State, services described in paragraph (4));

"(4)(A) except as otherwise provided in this subsection, and subject to subparagraph (B), a charge will be imposed --

"(i) for services listed in section 1905(a)(1) which equals and does not exceed $1 per day, and

"(ii) for services listed in paragraphs (2), (5), and (9) of section 1905(a) which equals and does not exceed $1 per visit; and

"(B) the charges specified in subparagraph (A) will be increased by such amounts as the Secretary may from time to time require (but such charges shall not be increased by a proportion greater than the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics).".

(3) Section 1916(a)(5), as redesignated (42 U.S.C. 1396o(a)(5)), is amended --

(A) by striking out "paragraph (2)(D)" and inserting instead "paragraph (3)(C)", and

(B) by striking out "up to twice the nominal amount established for outpatient services" and inserting instead "up to twice the nominal amount which the State would be permitted to charge for services under the State plan reimbursed at the same rate as hospital emergency room services".

(b)(1) Section 1916(b)(2) (42 U.S.C. 1396o(b)(2)) is amended by striking out "with respect to --" and all that follows and inserting instead "with respect to services furnished to an individual who is an impatient in a hospital, skilled nursing facility, intermediate care facility, or other

medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,".

(2) Section 1916(b) (42 U.S.C. 1396o(b)) is further amended by redesignating paragraph (3) as paragraph (5) and inserting after paragraph (2) the following new paragraphs:

"(3) at the option of the State, no deduction, cost sharing, or similar charge will be imposed under the plan with respect to --

"(A) services (other than services described in paragraph (4)) furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

"(B) services (including, at the option of the State, services described in paragraph (4)) furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy (or, at the option of the State, any services furnished to pregnant women),

"(C) emergency services (as defined by the State) (including, at the option of the State, services described in paragraph (4)), or

"(E) services (including, at the option of the State, services described in paragraph (4)) furnished

to an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled;

"(4)(A) except as otherwise provided in this subsection, and subject to subparagraph (B), a charge will be imposed --

"(i) for services listed in section 1905(a)(1) which equals and does not exceed $2 per day, and

"(ii) for services listed in paragraphs (2), (5), and (9) of section 1905(a) which equals and does not exceed $1.50 per visit; and

"(B) the changes specified in subparagraph (A) will be increased by such amounts as the Secretary may from time to time require (but such charges shall not be increased by a proportion greater than the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics).".

(3) Section 1916(b)(5), as redesignated (42 U.S.C. 1396o(b)(5)), is amended --

(A) by striking out "paragraph (2)(D)" and inserting instead "paragraph (3)(C)", and

(B) by striking out "up to twice the nominal amount established for outpatient services" and inserting instead "up to twice the nominal amount which the State would be permitted to charge for services under the State plan

reimbursed at the same rate as hospital emergency room services".

(c) Section 1916(d) (42 U.S.C. 1396o(d)) is repealed.

(d) The matter in section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) following subparagraph (D) is amended in clause IV by striking out "Section 1916(a)(2) or (b)(2)" and inserting instead "section 1916(a) or (b)".

(e) Section 1903 (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

"(w) Notwithstanding any other provision of this section, no payment shall be made to a State under this section for expenditures for medical assistance equal to the amount of the copayments that the State would have been permitted to charge under this title if it had not elected to exempt services described in subsections (a)(3)(B) and (C) and (b)(3)(B) and (C) of section 1916 from copayments to which they would otherwise be subject under subsections (a)(4) and (b)(4) of section 1916.

(f) The amendments made by this section shall become effective with respect to services furnished after September 1983, except that, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order to meet the additional requirements imposed by this section, the State plan shall not be regarded as failing to comply with the requirements of that title, and payment under section 1903 of that Act (42 U.S.C. 1396b) shall not be denied, with respect to expenditures in

accordance with section 1902(a)(14) of that Act (42 U.S.C. 1396a(a)(14)) as in effect before enactment of this Act, before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

Subtitle C - Administrative Changes

Repeal of Exclusion of For-Profit Organizations from Research and Demonstration Grants

Sec. 221. (a) Section 1110(a)(1) (42 U.S.C. 1310(a)(1)) is amended in the first sentence by striking out "nonprofit".

(b) Section 402(a)(1) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)(1)) is amended in the first sentence by striking out "nonprofit".

Amendments to Requirements for Medical Review and Independent Professional Review

Sec. 222. (a) Section 1902(a)(26) (42 U.S.C. 1396a(a)(26)) is amended to read as follows:

"(26) if the State plan includes medical assistance for inpatient mental hospital services, (A) provide, with respect to each patient receiving such assistance, for a regular program of medical review (including medical evaluation) of his need for such care, and for a written plan of care; (B) provide for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving such assistance, including (i) the adequacy of the services

available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and (C) provide for full reports to the State agency by each medical review team of the findings of each inspection under clause (B), together with any recommendations;".

(b) Section 1902(a)(31) (42 U.S.C. 1396a(a)(31)) is amended to read as follows:

"(31) with respect to skilled nursing facilities (and with respect to intermediate care facility services, where the State plan includes medical assistance for such services) (A) provide, with respect to each patient receiving such assistance, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such care; (B) provide, with respect to each facility within the State, for periodic on-site inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to

each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and (C) provide for full reports to the State agency by each independent professional review team of the findings of each inspection under clause (B), together with any recommendations;".

(c) Section 1902(a) (42 U.S.C. 1396a(a)) is amended, in the matter following paragraph (45) (as added by section 211(a)(2)(C) of this Act), by striking out "(26)".

Repeal of Special Tuberculosis Treatment Requirements

Sec. 223. (a) Section 1902(a)(28) (42 U.S.C. 1396a(a)(28)) is amended by striking out "and tuberculosis".

(b) Section 1903(g)(1) (42 U.S.C. 1395b(g)(1)) is amended, in the matter preceding subparagraph (A) --

(1) by striking out "(including an institution for tuberculosis)" and

(2) by striking out "(including tuberculosis hospitals)".

(c) Paragraphs (1), (4)(A), (14), (15), and (18)(B) of section 1905(a) (42 U.S.C. 1396d(a)) are each amended by striking out "tuberculosis or".

Elimination of Utilization Review
and Utilization Control Requirements

Sec. 224. (a) Section 1902(a)(30) (42 U.S.C. 1396a(a)(30)) is amended by striking out "(including but not limited to utilization review plans as provided for in section 1903(i)(4))".

(b) Section 1902(a) (42 U.S.C. 1396a(a)) is amended in the second sentence in the first unnumbered paragraph following paragraph (45) (as added by section 211(a)(2)(C) of this Act) by striking out ", and of section 1903(i)(4),".

(c)(1) Section 1903(g) (42 U.S.C. 1396(g)) is repealed.

(2) The amendment made by paragraph (1) shall be effective with respect to calendar quarters beginning after the earlier of June 1983 and the effective date of this Act.

(d) Section 1903(i) (42 U.S.C. 1396b(i)) is amended --

(1) by striking out subparagraph (4), and

(2) by renumbering subparagraphs (5) and (6) as (4) and (5), respectively.

Requirement that States Obtain Taxpayer Identification Numbers as a Condition of Receiving Medical Assistance

Sec. 225. (a) Section 1902(a) (as amended by section 211(a)(2) of this Act) (42 U.S.C. 1396a(a)) is further amended --

(1) by striking out "and" at the end of paragraph (44),

(2) by striking out the period at the end of paragraph (45) and inserting instead "; and", and

(3) by inserting after paragraph (45) the following new paragraph:

"(46) provide that, as a condition of eligibility under the plan, each individual applying for or receiving medical assistance shall furnish to the State agency his taxpayer identification number (or numbers, if he has more than one such number), or shall apply for a taxpayer identification number if he does not have one.".

(b)(1) The amendments made by subsection (a) shall become effective October 1, 1983, except that, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires legislation in order to meet the additional requirements imposed by this section, the State plan shall not be regarded as failing to comply with the requirements of that title, and Federal payments under section 1903 of that Act (42 U.S.C. 1396b) shall not be reduced with respect to expenditures by the State for medical assistance for individuals failing to comply with these additional requirements, before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

Verification that Medical Services Have Been Furnished as Claimed

Sec. 226. (a) Section 1902(a) (as amended by section 225(a) of this Act) (42 U.S.C. 1396a(a)) is further amended --

(1) by striking out "and" at the end of paragraph (45),

(2) by striking out the period at the end of paragraph (46) and inserting instead "; and", and

(3) by inserting after paragraph (46) the following new paragraph:

"(47) provide for an effective method of verifying, by appropriate sampling techniques or other methods approved by the Secretary, whether services billed by all participating providers were furnished as claimed to individuals entitled to medical assistance under the State plan.".

(b) Section 1903(a)(3)(B) (42 U.S.C. 1396b(a)(3)(B)) is amended by striking out "and which include" and all that follows before the semicolon.

Authority to Waive Requirements with Respect to the Territories

Sec. 227. Section 1902(j) (42 U.S.C. 1396a(j)) is amended --

(1) by inserting before "American Samoa" the first place it occurs "Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and", and

(2) by striking out "American Samoa" the second place it occurs and inserting instead "such jurisdiction".

Termination of Agreements with Institutions and Entities Where Owners or Certain Other Individuals Have Been Convicted of Certain Offenses

Sec. 228. Section 1903(n) (42 U.S.C. 1395b(n)) is amended by inserting "terminate or" after "The State agency may".

Elimination of Requirement for Accreditation of Psychiatric Hospitals by Joint Commission on Accreditation of Hospitals

Sec. 229. Section 1905(h)(1)(A) (42 U.S.C. 1395d(h)(1)(A)) is amended to read as follows:

"(A) inpatient services which are provided in an institution which satisfies the requirements of paragraphs (1), (2), and (4) of section 1861(f), and which maintains clinical records on all patients;".

Modification of Type of Hearing Required Before Secretary May Cancel Approval of A Skilled Nursing Facility or Intermediate Care Facility

Sec. 230. Section 1910(c)(2) (42 U.S.C. 1396i(c)(2)) is amended in the first sentence by striking out "a hearing by the Secretary to the same extent as is provided in section 205(b)" and inserting instead "a hearing on the record before an official designated by the Secretary at which the entity is entitled to be represented by counsel".

Flexibility in Setting Payment Rates for Hospitals Furnishing Long Term Care Services

Sec. 231. Section 1913(b) (42 U.S.C. 1396l(b)) is amended to read as follows:

"(b) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished pursuant to subsection (a), shall be at a payment rate established by the State in accordance with the requirements of section 1902(a)(13)(A) (which rate may but need not be the same as any rate established by the State for such services furnished by a skilled nursing or intermediate care facility).".

Amendments to Authority for Home and Community-Based Care Waivers

Sec. 232. (a) Section 1915(c)(2)(E) (42 U.S.C. 1396n(c)(2)(E)) is amended by inserting "both quarterly and" before "annually".

(b) Section 1915(c)(3) (42 U.S.C. 1396n(c)(3)) is amended in the second sentence to read as follows: "A waiver under this subsection shall be for an initial term, at the Secretary's discretion, of one, two, or three years and, upon the request of a State, shall be extended for additional periods of one, two, or three years unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.".

Authority of the Secretary to Issue and Enforce Subpoenas

Sec. 233. Title XIX is amended by adding at the end the following new section:

"Sec. 1918. The provisions of sections 205(d) and (e) shall apply with respect to this title to the same extent as they are applicable with respect to title II.".

Interest Payments on Disputed Claims

Sec. 234. (a) Section 961(b) of the Omnibus Reconciliation Act of 1980 (42 U.S.C. 1396b nt.) is amended by striking out "expenditures for services furnished" and inserting instead "amounts claimed by the State".

(b) The amendment made by subsection (a) shall be effective as if it had originally been included in the Omnibus Reconciliation Act of 1980.

TITLE III - OTHER HEALTH CARE FINANCING PROVISIONS

Repeal of Authority for Payments to Promote Closing and Conversion of Underutilized Hospital Facilities

Sec. 301. (a)(1) Section 1884 (42 U.S.C. 1395uu) is repealed.

(2) Section 1903(e) (42 U.S.C. 1396b(e)) is repealed.

(b)(1) Section 2101 of the Omnibus Budget Reconciliation Act of 1981 (42 U.S.C. 1395uu nts.) is repealed.

(2) Section 2100 of that Act is amended by striking out in the table of contents of title XXI of that Act the matter pertaining to section 2101.

(c) The amendments made by subsection (a) shall not apply to any transitional allowance established by the Secretary of Health and Human Services under section 1884 of the Social Security Act before the date of enactment of this Act.

Presidential Appointment of, and Executive Level IV Pay Rate for, the Administrator of the Health Care Financing Administration

Sec. 302. (a) Title XI is amended by inserting after section 1116 the following:

"Appointment of the Administrator of the Health Care Financing Administration

"Sec. 1117. The Administrator of the Health Care Financing Administration shall be appointed by the President by and with the advice and consent of the Senate.".

(b) Section 5315 of title 5, United States Code, is amended by adding at the end the following:

"Administrator of the Health Care Financing Administration.".

(c) The amendments made by the preceding subsections shall apply to appointments made after the date of enactment of this Act.

Increased State Flexibility Under the Capital Expenditures Review Program

Sec. 303. (a) Section 1122(b) (42 U.S.C. 1320a-1(b)) is amended to read as follows:

"(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency of the government of the State) may make, and submit to the Secretary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility in the State that the agency chooses to review.".

(b) Section 1122(d) (42 U.S.C. 1320a-1(d)) is amended to read as follows:

"(d) If the Secretary determines that --

"(1) the planning agency designated in the agreement described in subsection (b) had not been given notice of any proposed capital expenditure subject to review by that agency (in accordance with such procedure or in such detail as may be required by that agency) by such reasonable time prior to obligation for such expenditure as specified by that agency, or

"(2)(A) the planning agency so designated had received such timely notice of the intention to make such

capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with standards, criteria, or plans developed to meet the need for adequate health care facilities, and

"(B) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b), granted to the person proposing such capital expenditure an opportunity for a hearing with respect to such findings,

then, for such period as he finds necessary to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles XVIII and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determining the Federal payments to be made under titles XVIII and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.".

(c) Section 1122(g) (42 U.S.C. 1320a-1(g)) is amended to read as follows:

"(g) For purposes of this section, a 'capital expenditure' is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) changes the bed capacity of the facility with respect to which such expenditure is made, or (2) substantially changes the services of the facility with respect to which such expenditure is made.".

(d) Section 1122(i) (42 U.S.C. 1320a-1(i)) is repealed.

(e) The amendments made by the preceding subsections do not apply --

(1) to a capital expenditure with respect to which a timely notice was received under section 1122(d)(1)(B)(i) of the Social Security Act (42 U.S.C. 1320a-1(d)(1)(B)(i)) (as in effect before the date of enactment of this Act) before 90 days after the date of enactment of this Act, or

(2) to a capital expenditure for which obligation was incurred before 90 days after the date of enactment of this Act.

Repeal of Requirement for Federal Funding of State Programs that Review Health Facility Capital Expenditures

Sec. 304. Section 1122(c) (42 U.S.C. 1320a-1(c)) is repealed.

Amendment to Requirements Concerning Reporting of Financial Interest

Sec. 305. Section 1124(a)(3)(A)(ii) (42 U.S.C. 1320a-3(a)(3)(A)(ii)) is amended by striking out "$25,000 or".

Exclusion of Certain Entities Owned or Controlled by Individuals Convicted of Medicare- or Medicaid-Related Crimes

Sec. 306. (a) Section 1128 (42 U.S.C. 1320a-7) is amended --

(1) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively, and

(2) by inserting after subsection (a) the following new subsection:

"(b) Whenever the Secretary determines, with respect to an entity, that a person who has a direct or indirect ownership or control interest of 5 percent or more in the entity, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such entity, is a person described in section 1126(a), the Secretary --

"(1) may bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such entity otherwise eligible to participate in such program;

"(2) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of the determination, and may require each such agency to bar the entity from participation in the program for such period as he may specify, which in the case of an entity specified in paragraph (1), may not exceed the period established pursuant to paragraph (1); and

"(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such entity of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.".

(b) Section 1128(d) (42 U.S.C. 1320a-7(d) (as redesignated by subsection (a)(1)) is amended --

(1) by inserting "or entity" after "Any person", and

(2) by inserting "or (b)" after "subsection (a)".

Elimination of the Peer Review Program

Sec. 307. (a) Part B of title XI is repealed.

(b)(1) The heading to title XI is amended by striking out "AND PROFESSIONAL STANDARDS REVIEW".

(2) Title XI is amended by striking out the part heading "Part A -- General Provisions".

(3) The third sentence of section 1101(a)(1) (42 U.S.C. 1301(a)(1)) is amended by striking out "and in part B of this title".

(4) Section 1832(a)(2)(F)(ii) (42 U.S.C. 1395k(a)(2)(F)(ii)) is amended by striking out everything

after "has determined that" through the end of subclause (III) and inserting instead "the physician is authorized to perform the procedure in a hospital located in the area in which the office is located".

(5) The matter in section 1861(v)(1)(G)(i) (42 U.S.C. 1395x(v)(1)(G)(i)) preceding subclause (I) is amended by striking out "a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate)" and inserting instead "the Secretary or such agent as the Secretary may designate".

(6) Section 1862(g) (42 U.S.C. 1395y(g)) is repealed.

(7) Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended --

(A) by adding "and" at the end of subparagraph (D) (as amended by section 122(a)(1) of this Act),

(B) by striking out subparagraph (E), and

(C) by redesignating subparagraph (F) (as added by section 122(a)(3) of this Act) as (E).

(8) The last sentence of section 1879(a) (42 U.S.C. 1395pp(a)) is amended by striking out "(including notification by a utilization and quality control peer review organization)".

(9) Section 1879(e) (42 U.S.C. 1395pp(e)) is amended by striking out ", quality control and peer review organization,".

(10) Section 1902(d) is repealed.

(11) Section 1903(a)(3) (42 U.S.C. 1396b(a)(3)) is amended --

(A) by striking out "and" at the end of subparagraph (B) and inserting instead "plus", and

(B) by striking out subparagraph (C).

(12) Section 402(a)(1) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1(a)(1)) is amended -

(A) by adding "and" at the end of subparagraph (I),

(B) by striking out "; and" at the end of subparagraph (J) and adding instead a period, and

(C) by striking out subparagraph (K).

(13) Section 928 of the Omnibus Reconciliation Act of 1980 (42 U.S.C. 1320c-15 nt.) is repealed.

(14) Section 1513(d)(1)(A) of the Public Health Service Act (42 U.S.C. 300A-2(d)(1)(A)) is repealed.

(15) Section 150 of the Tax Equity and Fiscal Responsibility Act of 1982 (42 U.S.C. 1320c nt.) is repealed.

(b) The amendments made by subsection (a) apply with respect to items and services furnished after September 1983.

SUMMARY OF PROPOSED MEDICARE PROSPECTIVE PAYMENT RATES ACT

Section 1 would assign the draft bill the short title "Medicare Prospective Payment Rates Act".

Section 2 would require prospective determination of payments under Medicare with respect to operating costs of inpatient hospital services instead of payments on the basis of reasonable cost. Prospectively determined payments would not be required for psychiatric, long-term, or children's hospitals. The Secretary of Health and Human Services could, by regulation, extend the prospective method to other cost elements of inpatient hospital services (such as capital-related costs and teaching costs) and to psychiatric, long-term, and children's hospitals. Deductibles and coinsurance would continue to be required of Medicare beneficiaries as under existing law and would continue to be deducted from the Medicare payments to hospitals, but no additional charges could be imposed on beneficiaries. Medicare payments for services payable under this section on a prospective basis, to or on behalf of health maintenance organizations (HMOs) or competitive medical plans (CMPs) that contract with Medicare on a cost basis, would be paid on that prospective basis. HMOs and CMPs that receive Medicare payments on a risk basis would continue to do so as under existing law, except as otherwise provided by section 4.

Section 3 specifies how Medicare payments for inpatient hospital services would be determined prospectively:

The Secretary would set a payment amount for each Medicare inpatient hospital discharge in fiscal year 1984 equal to the national standard rate for the diagnosis related group (DRG) to which the discharge belonged, adjusted for regional differences in hospital wage levels, and updated to fiscal year 1983 by the estimated rate of change of hospital costs industry-wide, and from fiscal year 1983 to fiscal year 1984 by the estimated increase in the hospital market basket index. The national standard rate for each DRG would be equal to the product of an appropriate cost level per discharge (determined by the Secretary) for all Medicare discharges and an appropriate weighting factor (determined by the Secretary) for that DRG.

The Secretary could revise the DRGs from time to time.

The Secretary would annually adjust the payment amounts determined for fiscal year 1984 to provide compensation that the Secretary in his judgment deemed adequate for efficiently and economically operated hospitals, taking into account such factors as changes in the cost per unit of goods and services, changes in productivity, and technological and scientific advances. He could also, from time to time, adjust the payment amounts to take into account such factors as changes he had made in the DRGs, changes in the portion of costs attributable

to wages, changes in the kinds of costs for which prospective payments were to be made (as he may have provided by regulation), or regional differences (or changes in those differences) in the cost per unit of goods and services other than wages. He could also establish payment amounts for new DRGs at levels comparable to amounts established for previous ones involving comparable use of hospital resources.

The Secretary could provide for exceptions and adjustments to meet the special needs of sole community hospitals. The Secretary could also pay additional amounts (as determined by the Secretary) for discharges whose length of stay exceeded by thirty days or more the mean length of stay of the discharges in a particular DRG.

The Secretary would publish a notice in the Federal Register by September 1 of fiscal year 1984 and of each succeeding fiscal year establishing the payment amounts for the coming fiscal year.

Payment amounts, exceptions, adjustments, and rules established under this section and related claims would not be subject to judicial review.

Section 3 would also repeal the cost limits and target amount provisions enacted by the Tax Equity and Fiscal Responsibility Act of 1982, except that the target amount provisions would continue to apply permanently to hospitals not paid on a prospective basis under the draft bill, and that the increase in target amounts permitted for fiscal year 1984 would be only the estimated increase in the hospital market basket index, rather than that increase plus 1 percent.

Section 4 would permit an HMO or a CMP that receives Medicare payments on a risk basis to choose to have the Secretary directly pay hospitals for inpatient hospital services furnished to Medicare enrollees of the HMO or CMP. The payment amounts would be at the appropriate DRG rate (or on the basis of reasonable cost, as applicable), and would be deducted from Medicare payments to the HMO or CMP.

Section 5 specifies that the amendments enacted by the draft bill would not affect the authority of the Secretary to develop, carry out, or continue experiments and demonstration projects.

Section 6 would enact conforming amendments.

Section 7 would make the amendments enacted by the draft bill effective with respect to items and services furnished by a hospital after its last cost reporting period that began before October 1983. The Secretary would appropriately reduce the payment amount for any discharge if the admission occurred

before the first cost reporting period that began after September 1983 to take into account amounts payable under Medicare under existing provisions of law for items and services furnished before that period. The Secretary would be required to publish a notice in the Federal Register by September 1, 1983, establishing the payment amounts for fiscal year 1984, and to allow for a period of public comment. The payment amounts would be effective as of October 1 (without the necessity for consideration of comments received), but the Secretary would be required to publish a notice by December 31 affirming or modifying the amounts after considering the comments. Any decreases in payment amounts in that notice would apply only to discharges occurring more than 30 days after its publication.

A B I L L

To provide for prospective payment rates under Medicare for inpatient hospital services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Short Title and References in Act

Section 1. (a) This Act may be cited as the "Medicare Prospective Payment Rates Act".

(b) The amendments in this Act apply to the Social Security Act.

Medicare Payments for Inpatient Hospital Services on the Basis of Prospective Rates

Sec. 2. (a) Section 1814(b) is amended --

(1) in the matter preceding paragraph (1), by striking out "and 1886", and

(2) by amending paragraphs (1) and (2) to read as follows:

"(1) with respect to operating costs of inpatient hospital services of other than psychiatric, long-term, or children's hospitals (and such costs of inpatient hospital services of psychiatric, long-term, or children's hospitals and such other costs of inpatient hospital services as the Secretary may prescribe from time to time by regulation), the amount determined prospectively as provided by section 1886, except as provided in paragraph (3) or under an exception granted under section 1886(d);

"(2) with respect to other costs of inpatient hospital services and with respect to other services, except as provided in paragraph (3) or in section 1888, --

"(A) the lesser of (i) the reasonable cost of the services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), and (ii) the customary charges with respect to the services, or

"(B) if the services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations) included in the determination of such reasonable cost as the Secretary finds will provide fair compensation to the provider for the services; or".

(b) The matter in section 1866(a)(2)(B)(ii) preceding subclause (I) is amended by inserting "or with respect to costs subject to section 1814(b)(1)" after "except with respect to emergency services".

(c)(1) Section 1886(d)(2)(A) is amended to read as follows:

"(2) Subparagraph (A)(ii) and subparagraph (B) of subsection (b)(2).".

(2) Subsection (d) of section 1886 is assigned the heading "Elimination of Lesser-of-Cost-or-Charges Provision", is redesignated as subsection (j), and is transferred to the end of section 1814.

Prospective Determination of Medicare Payment
Rates for Inpatient Hospital Services

Sec. 3. (a) Section 1886 is amended to read as follows:

"Prospective Determination of Payment
Rates for Inpatient Hospital Services

"Sec. 1886. (a)(1) The Secretary shall determine a payment amount for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services for which payment may be made under part A of this title. That amount shall be equal to a national standard rate per discharge for the diagnosis related group to which that discharge belongs (the product of an appropriate standard cost level per discharge determined by the Secretary for all discharges involving inpatient hospital services for which payment may be made under part A of this title and an appropriate weighting factor determined by the Secretary for that diagnosis related group), adjusted for regional differences in hospital wage levels, and updated to fiscal year 1983 by the estimated rate of change of hospital costs industry-wide, and from fiscal year 1983 to fiscal year 1984 by the percentage increase defined in paragraph (2).

"(2) For purposes of paragraph (1), the 'percentage increase' shall be equal to the percentage, estimated by the Secretary, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted

indicators of changes in wages and prices which are representative of the mix of such goods and services, for fiscal year 1984 exceeds the cost of the mix of such goods and services for fiscal year 1983.

"(b) The Secretary may from time to time make changes (including the establishment of new groups) in the diagnosis related groups referred to in subsection (a).

"(c)(1) The Secretary shall, for hospital discharges in fiscal year 1985 and in each succeeding fiscal year, adjust (uniformly, or individually for specified diagnosis related groups) the payment amounts determined under subsection (a) so as to provide compensation that the Secretary in his judgment deems adequate for efficiently and economically operated hospitals, taking into account such factors as changes in the cost per unit of goods and services, changes in productivity, and technological and scientific advances.

"(2) The Secretary may, from time to time, adjust the payment amounts determined under subsection (a) to take into account such factors as changes made in the diagnosis related groups, changes in the portion of costs attributable to wages, changes in the kinds of costs subject to the provisions of this section (pursuant to regulations as provided in section 1814(b)(1)), or regional differences (or changes in those differences) in the cost per unit of goods or services other than wages. The Secretary may also, from time to time,

establish payment amounts for new diagnosis related groups at levels comparable to amounts established for previous diagnosis related groups involving comparable use of hospital resources.

"(d)(1) The Secretary may provide (on a general, class, or individual basis) for exceptions and adjustments to the payment amounts established under the previous subsections to take into account the special needs of sole community hospitals.

"(2) The Secretary may provide for additional payment amounts (as determined by the Secretary) for any discharge whose length of stay exceeds by thirty or more days the mean length of stay of the discharges in the diagnosis related group to which that discharge belongs.

"(e) The Secretary shall publish in the Federal Register a notice of the payment amounts established under subsection (c)(1) no later than the September 1 preceding the beginning of the fiscal year to which the amounts are to apply.

"(f) Payment amounts, exceptions, adjustments, and rules established under this section shall be final and conclusive, and claims related thereto (including claims related to administrative procedures used or actions authorized but not taken) shall not be subject to review or consideration by any court under any form of judicial process or procedure.".

(b) Title XVIII is amended by adding at the end the following:

"Target Inpatient Hospital Amounts for Certain Hospitals

"Sec. 1888. (a) Subject to the provisions of section

1813, if the operating costs per discharge of inpatient hospital services for a cost reporting period of a hospital that does not receive payments under section 1814(b)(1) --

"(1) are less than or equal to the target amount (as defined in subsection (c)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge basis shall be equal to the amount of such operating costs, plus --

"(A) 50 percent of the amount by which the target amount exceeds the amount of such operating costs, or

"(B) 5 percent of the target amount, whichever is less, or

"(2) are greater than that target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge basis shall be equal to (A) the target amount, plus (B) in the case of cost reporting periods beginning before October 1, 1984, 25 percent of the amount by which the amount of such operating costs exceeds the target amount.

"(b)(1) For purposes of subsection (a), the term 'target amount' means, with respect to a hospital for a particular 12 month cost reporting period, --

"(A) in the case of the first such reporting period for which this subsection is in effect, the target amount

under section 1886(b)(3) (as in effect before enactment of the Medicare Prospective Payment Rates Act) for the preceding 12 month cost reporting period, and

"(B) in the case of a later reporting period, the target amount for the preceding 12 month cost reporting period,

increased by the applicable percentage increase under paragraph (2) for that particular cost reporting period.

"(2) For purposes of paragraph (1), the 'applicable percentage increase' for any 12 month cost reporting period shall be equal (A) the percentage, estimated by the Secretary, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of such goods and services, for that cost reporting period exceeds the cost of the mix of such goods and services for the preceding 12 month cost reporting period, plus (B) in the case of cost reporting periods beginning after September 30, 1984, 1 percent.".

"(c) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of the

hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which the increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, the method as the Secretary deems appropriate, including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

"(d) In the case of any hospital having any cost reporting period of other than a 12 month period, the Secretary shall determine the 12 month period which shall be used for purposes of this section.

"(e)(1) The Secretary shall provide for an adjustment under this subsection in the amount of payment otherwise provided a hospital under this section in the case of a hospital which, as of August 15, 1982, was subject to the taxes (hereinafter in this subsection referred to as the 'FICA taxes') imposed by section 3111 of the Internal Revenue Code of 1954 and which is not subject to such taxes for part or all of a cost reporting period.

"(2) In making such an adjustment for a cost reporting period the Secretary shall estimate the amount of the operating costs of inpatient hospital services that would have resulted

if the hospital was subject to the FICA taxes during that period. In making that estimate the Secretary shall reduce the amount of the FICA taxes that would have been paid (but not below zero) by the amount of costs which the hospital demonstrates to the satisfaction of the Secretary were incurred in the period for pensions, health, and other fringe benefits for employees (and former employees and family members) comparable to, and instead of, the benefits provided under title II and this title.

"(3) If a hospital's operating costs of inpatient hospital services estimated under paragraph (2) is greater than the hospital's operating costs of inpatient hospital services determined without regard to this subsection for a cost reporting period, then the Secretary shall reduce the amount otherwise paid the hospital (respecting operating costs of inpatient hospital services) under this title for the period by the amount by which the amount that would have been paid the hospital (if the amount of the operating costs of inpatient hospital services estimated under paragraph (2) were treated as the amount of the operating costs of inpatient hospital services) exceeds the amount that would have been paid the hospital if this subsection did not apply; except that, in making such a determination for a cost reporting period beginning on or after October 1, 1984, clause (B) of subsection (a)(2) shall continue to apply.".

Payments by Secretary to Hospitals on Behalf of Health Maintenance Organizations and Competitive Medical Plans

Sec. 4. (a) Section 1876(g) is amended by adding at the end the following:

"(4) A risk-sharing contract under this subsection may, at the option of an eligible organization, provide that the Secretary --

"(A) will reimburse hospitals either for the reasonable cost (as determined under section 1861(v)) or for payment amounts determined in accordance with section 1886, as applicable, of inpatient hospital services furnished to individuals enrolled with such organization pursuant to subsection (d), and

"(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.".

Effect of Amendments on Authority for Experiments and Demonstration Projects

Sec. 5. The amendments enacted by this Act shall not affect the authority of the Secretary of Health and Human Services to develop, carry out, or continue experiments and demonstration projects.

Conforming Amendments

Sec. 6. (a) The matter in section 1814(g) preceding paragraph (1) is amended by inserting "(or would be if subsection (b)(1) did not apply)" after "1861(v)(1)(D)".

(b) Section 1814(h)(2) is amended by striking out "the reasonable costs for such services" and inserting "the amount that would be payable for such services under paragraphs (1) and (2) of subsection (b)".

(c) The matter in section 1835(e) preceding paragraph (1) is amended by inserting "(or would be if section 1814(b)(1) did not apply)" after "1861(v)(1)(D)".

(d) The matter in section 1861(v)(1)(G)(i) following subclause (III) is amended by striking out "on the basis of the reasonable cost of inpatient hospital services" and inserting instead "as provided in paragraphs (1) and (2) of section 1814(b)".

(e) Section 1861(v)(2)(A) is amended by striking out "an amount equal to the reasonable cost of" and inserting instead "the amount that would be taken into account with respect to".

(f) Section 1861(v)(2)(B) is amended by striking out "the equivalent of the reasonable cost of".

(g) Section 1861(v)(3) is amended by striking out "the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1))" and inserting instead "the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations".

(h) Section 1861(v)(7)(B) is amended to read as follows:

"(B) For further limitations on reasonable cost for operating costs of inpatient hospital services, see section 1888.".

(i) Section 1861 is amended by inserting after subsection (m) the following:

"(n) The term 'operating costs' with respect to inpatient hospital services means routine operating costs, ancillary service operating costs, and special care unit operating costs.".

(j) Section 1861 is amended by inserting after subsection (aa) the following:

"(bb) The term 'long-term hospital' means a hospital whose average inpatient length of stay (as determined by the Secretary) is greater than 25 days, and any other hospital with appropriate characteristics as determined by the Secretary.".

(k) Section 1861 is amended by adding at the end the following:

"(ee) The term 'children's hospital' means a hospital whose inpatients are predominantly individuals under 18 years of age.

"(ff) The term 'sole community hospital' means a hospital that, by reason of factors such as isolated location or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographical area who are entitled to benefits under part A.".

(l) The first sentence of section 1881(b)(2)(A) is amended by striking out "section 1861(v)" and inserting instead "paragraphs (1) and (2) of section 1814(b)".

(m) Section 1883(e) is amended --

(1) by striking out "payment" and inserting instead "reasonable costs", and

(2) by striking out "title XVIII reimbursement" and inserting instead "reasonable costs under this title".

(n) Section 1887(a)(1)(B) is amended by striking out "on a reasonable cost basis" and inserting instead "as provided in paragraphs (1) and (2) of section 1814(b)".

Effective Date

Sec. 7. (a)(1) The amendments made by this Act apply to items and services furnished by or under arrangements with a hospital after its last cost reporting period that has begun before October 1983.

(2) A change in a hospital's cost reporting period that has been made after November 1982 shall be recognized for purposes of this section only if the Secretary of Health and Human Services finds good cause for that change.

(b) The Secretary shall make an appropriate reduction in the payment amount under section 1814(b)(1) of the Social Security Act (as amended by section 2(a)(2) of this Act) for any discharge, if the admission has occurred before a hospital's first cost reporting period that has begun after September 1983, to take into account amounts payable under title XVIII of that Act (as in effect before the date of enactment of this Act) for items and services furnished before that period.

(c) The Secretary shall publish in the Federal Register a notice of the payment amounts established under subsection (a) of section 1886 of the Social Security Act (as amended by section 3(a) of this Act) no later than September 1, 1983, and allow for a period of public comment thereon. The payment amounts shall become effective on the following October 1 without the necessity for consideration of comments received, but the Secretary shall, by notice published in the Federal Register, affirm or modify the amounts by the following December 31 after considering those comments. A modification that reduces a payment amount shall apply only to discharges occurring after 30 days after notice of the modification is published in the Federal Register. Rules to implement that subsection shall, and exceptions, adjustments, or additional payment amounts under section 1886(d) of the Social Security Act may, be established in accordance with the procedure described in the preceding sentences of this paragraph.

○